2000

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Angela Joan Rubineau
*Yale University*


# LESBIAN, BISEXUAL, AND GAY GRADUATES OF THE YALE SCHOOL OF MEDICINE AND THEIR HETEROSEXUAL PEERS: ATTITUDES AND EXPERIENCES, 1969-1998

A. J. RUBINEAU
YALE UNIVERSITY
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# Lesbian, Bisexual, and Gay Graduates of the Yale School of Medicine and Their Heterosexual Peers: Attitudes and Experiences, 1969-1998

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Medicine

by

Angela Joan Rubineau

May 2000

## ABSTRACT

The purpose of the study is to examine physician graduates of the Yale School of Medicine's attitudes toward and experiences with homosexual patients and colleagues, and to document for the first time the unique experiences of the lesbian, bisexual, and gay ("lesbigay) Yale graduates themselves. In November 1999, a questionnaire was mailed to all 2703 living graduates of Yale School of Medicine from the class of 1969 to the class of 1998. The questionnaire asked for information on personal and professional demographics; experiences with lesbigay acquaintances currently and while at Yale; and attitudes toward homosexuality and Yale's sexuality education. Of the 1086 responding graduates (response rate 40.2%), anti-gay bias was very rare, with only 1% displaying "homophobic" attitudes on a standardized scale, and only 1.2% of respondents saying they would deny medical school admission to a qualified gay, lesbian, or bisexual applicant. The majority of respondents (55%) have heard disparaging remarks about lesbigay patients, and most (65%) have worked with a lesbigay colleague. Respondents who a have lesbigay colleague, friend, or family member are significantly more positive toward homosexuality than those who don't, and among recent graduates, over 95% report knowing a lesbigay Yale Medical student. One in 15 respondents (6.5%) currently identifies as lesbigay; of these, more than a third (36%) have been the victims of discrimination based on their sexual orientation, including 5 people (7%) who have been physically attacked for being gay. In conclusion, Yale Medicine graduates from the past thirty years display less anti-gay bias than any previously published study of physicians. Openly gay physicians have become increasingly common, and interaction with them and

with lesbigay friends and colleagues is associated with more positive attitudes toward lesbigays. Lesbigays make up a significant proportion of Yale Medicine graduates, and their sexual orientation has caused them professional and personal difficulties.

## ACKNOWLDEGEMENTS

I wish to give heartfelt thanks

to all the respondents who shared their intimate thoughts, especially to the brave lesbians, bisexuals, and gay men whose trials have made my path so much easier to walk;

to Dr. Alex Ortega, for cracking the whip, but gently;

to Cindy Andrien, for believing in all of us, and for making it look easy;

to Daniel, for coming out with me on day one;

and to my precious love Brian, for everything and for always.

# TABLE OF CONTENTS

# INTRODUCTION

In Section 1, Physicians' Attitudes, I will chronicle how physicians' attitudes toward homosexuality have been shaped by researchers, politicians, and other leaders in recent centuries, and how physicians themselves have struggled with the topic of homosexual identity and behavior. Next, I will recount contemporary studies describing three decades' worth of physicians' attitudes towards homosexuality, including the incendiary debate surrounding the medicalization and de-medicalization of homosexuality. Section 2, The Gay Doctor, is devoted to existing research on the experiences of lesbigay physicians and physicians in training. Since the data on doctors are very scarce, I will also reference publications from related professional fields, including business and law.

## *SECTION 1: PHYSICIANS' ATTITUDES*

### Why should we care about attitudes?

What is the relevance of doctor's attitudes? As long as they are good doctors, does it really matter what they believe? Yes, say the researchers featured in this section, it most certainly does. Physicians' attitudes are important to study for several reasons, not the least of which is this truth: attitudes influence behavior.

Despite the field of medicine's assertion that physicians are selfless impartial palettes whose only goal is to put their patients' needs first, studies suggest that physicians' attitudes do indeed have an impact on the quality of patient care delivered. Several striking examples of this were documented in a recent landmark study undertaken

by the Gay and Lesbian Medical Association (GLMA) and published in 1994.[1] The study was the first of its kind, surveying over 700 members of an organization of lesbian, gay, and bisexual physicians & medical students in the U.S. and Canada. Among the more disturbing examples recounted by respondents:

> "One of my residents…spoke of a gay man with HIV in the ICU. He told me that he believed HIV was God's punishment of homosexuality, that he deserved to die, and that, in fact, all gay or lesbian people should be dead." A female medical student.
>
> "A patient with a peri-rectal abscess went to visit another physician. He was in pain, with fever and chills. The doctor proceeded to lecture him about being gay and said he would not treat him. He then came to see me, and I had to hospitalize him because he was so sick." A Southern California physician.
>
> "Other OB/GYNs here don't do pap smears on a lot of their openly lesbian patients. They don't seem to take complaints of pelvic pain seriously." A rural OB/GYN.

Moreover, it has been demonstrated that lesbigay patients' negative experiences with health care providers, and fears of their physician's negative attitudes, actually hinder patients both from seeking necessary health care and from providing an honest and complete medical history to the caregivers they do visit. A 1980 study of 622 readers of a gay periodical by Larry Dardick suggested that patients who believed their physicians were unsupportive of homosexuality (over a quarter of respondents) were much less likely to disclose their sexual orientation to the provider or to give a complete medical history[2]. Being less open with their physician was associated with less satisfaction, less

ease of communication with health professionals, and for men, a lower frequency of STD check ups. A review of similar studies Harrison found that between 31% and 89% of health care professionals had reacted negatively to their patients "coming out" as gay or lesbian, with responses ranging from outright rejection or hostility, to pity and condescension.[3]

Harrison also cites a 1990 publication documenting that 50% of lesbians studied, despite being well-educated professionals, rarely or never sought routine GYN care. The conclusion of the study was that "these women had access to health care, yet chose not to use it because of negative experiences with health care professionals."

The impact of today's physicians' attitudes goes well beyond today's patients. Their attitudes will also be reflected in tomorrows' hospitals and clinics. Since physicians are responsible for selecting and training the next generation of doctors, their attitudes will influence which medical school applicants are selected or rejected, and which curricula are taught to tomorrows' medical students. For example, a 1986 survey of physicians in a California county medical society (Mathews) revealed that over a third of respondents (36.3%) agreed that qualified gay applicants should not be accepted into medical school[4]. However, it was the oldest group of doctors who were most likely to agree. In 1988, only 10.8% of Family Practice residents surveyed in the same region, Southern California, agreed, suggesting that perhaps those physicians who are earlier in their careers may harbor more positive attitudes toward homosexuality.[5] The most recent study published that asked the same question, found that of more than 1,000 New Mexico physicians surveyed in 1996, only 4.3% said they would refuse medical school admission to a lesbigay applicant[6]. Although regional differences may help explain the findings,

since all three studies focused on a single geographic area each, the differences are dramatic enough to encourage us to entertain other explanations. It is worth noting that to refuse a student admission to medical school based solely on sexual orientation is forbidden by school policy in both University of New Mexico and University of Southern California, and in no less than 61 of the 126 LCME-accredited schools, according to a 1995 study of sexual orientation and nondiscrimination policies.[7]

In addition to determining the makeup of medical school classes, doctors' attitudes influence who will be accepted into residency training programs. As recently as 1996, 25% of Family Practice residency directors surveyed admitted that they would rank an openly gay candidate lower due to their lesbigay orientation, and several directors insisted they would not rank such a candidate at all[8].

Today's doctors in academic medicine also carry the responsibility for developing curricula for medical schools. The topic of how to teach sexuality to medical students has been debated in the literature for decades. As early as the 1950's, educators were publicly struggling to define the role of human sexuality in scientific medical education. In 1963, only a single medical school "was attempting any formal instruction in this important and often troublesome area."[9] A 1969 study published in the New England Journal of Medicine found that 91.5% of 397 medical students surveyed felt poorly equipped to counsel their patients on sexual matters.[10] Students began to demand change, and their schools responded. By 1975 almost all medical schools had begun incorporating sexuality education into their curricula.[11] It is not clear through the literature what the content of these courses actually was, although there is a suggestion

that they included topics such as contraception, sexually transmitted diseases, "marital sexual adjustment," impotence, and homosexuality.

A dramatic contemporary example of how physicians' attitudes can influence curriculum was demonstrated by a survey published in 1998 of curriculum content on homosexuality/bisexuality specifically in Departments of Family Medicine.[12] The author surveyed 116 directors of Family Medicine Departments, and received 95 (82%) responses. She found not only that more than half of responding directors reported offering absolutely no teaching about homosexuality, but that the attitudes of those in power clearly have an impact on this figure. "In the most extreme response, one survey was returned with the identification number torn off and the comment, 'We do not think it proper to endorse, condone, or propagate deviant behavior as 'normal' sexual function.'"

In conclusion, the literature strongly supports the idea that physicians' attitudes do indeed play a powerful and incontrovertible role in patient care, health policy, and even medical education.

## But can we do anything about these attitudes?

Clearly, attitudes are important. But are they immutable? Can attitudes, particularly negative ones, be changed, through education or even through experience? And if so, does improving attitudes actually result in better patient care? According to the data, the answers to the above questions appear to be no, they're not immutable; yes, they can be changed through both education and personal experience; and yes, it is likely that this will result in better patient care. These data are presented below.[13-20]

Interventions to reduce negative attitudes toward homosexuality among physicians have taken several forms. These include presenting classroom education, offering personal testimonial from lesbigay patients and physicians, role modeling by attending physicians, and forming personal relationships with lesbigay individuals. In addition to these direct methods, organizations have also crafted policy statements to attempt to influence attitudes of their members. Several of these approaches and discussions of their effectiveness are presented below.

In the medical school setting, as early as the 1960's, medical educators were addressing homosexuality in the classroom, trying to inform students and to shape their attitudes. According to Dr. Woods, a study of 75 senior medical students who participated in one of the first medical school classes on human sexuality found that students had received helpful instruction regarding homosexuality in particular.[13] "Many felt this [class] had enabled them to see the homosexual in a patient role rather than as an object of ridicule." A 1977 study of 96 second-year medical students found that an intensive course on human sexuality resulted in a dramatic reduction in reported unfavorable ratings toward homosexuality.[14] However, since no follow-up was conducted, it cannot be said whether this was a lasting effect, or simply a "change in immediate feelings and attitudes."

Another promising approach toward attitude change takes advantage of the traditional model of medical training. Given the strong hierarchical structure of medical education, the role of the attending physician to influence medical students and residents cannot be overlooked. The clinical years also provide an opportunity for influencing attitudes.[15] In fact, in a study of physicians' attitudes toward treating persons with AIDS,

findings suggested that "medical attending role modeling is an important way through which attitudes are fostered."

Fewer data are available for the effectiveness of interventions on physicians who are already in practice. One small-scale study investigated a Continuing Medical Education (CME) curriculum that had been developed to inform Primary Care Providers about Lesbian Health issues.[16] Participants, including physicians and midlevel practitioners, reported increased awareness, sensitivity, and knowledge about lesbian health care after the sessions. Among the responses were: "I am more conscious of using inclusive language and not making assumptions about people." However, this study also demonstrated that not all clinicians' attitudes are open to such efforts. At least one of the 103 participants maintained his original negative attitudes, and commented after the sessions, "Lesbians are morally wrong. The Bible says so. I refuse to answer these questions."

Interventions that have been proposed, but have not yet been evaluated in the literature, include increasing personal contact with lesbigay peers or family members. While several studies have suggested that doctors and medical students who have lesbigay friends or family members are less likely to harbor negative attitudes towards gays, it has not yet been demonstrated whether such associations actually improve attitudes, or whether lesbigays simply choose not to disclose their sexuality to people whom they suspect harbor negative attitudes. Nevertheless, the phenomenon persists. The previously cited CME study found that "respondents who reported having a friend or family member who is lesbian has a more accurate knowledge of lesbian identity and behavior, held fewer stereotypes, and were less likely to regard lesbians as mentally ill or

unfit mothers." And a 1988 survey of 203 first year medical students found that "students with a homosexual friend feel more comfortable with homosexual patients."[17] Perhaps simply associating with fellow lesbigay medical students, residents, and physician colleagues is powerful enough to nurture more positive attitudes toward lesbigay patients. The answer is not yet clear.

The final strategy for influencing doctors' attitudes toward homosexuality has been through organizational policymaking. For example, when the American Psychological Association (APA) voted in 1973 to remove homosexuality from the defining Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-II),[18] many psychiatrists and other physicians were compelled to listen to the debates on the topic, and to rethink their own attitudes. As Dr. Howard Brown, physician and leader of the National Gay Task Force, joked the day following the APA's decision, "Never in history had so many people been cured in so little time."[19] More recently, the American Medical Association (AMA) voted to include in its nondiscrimination bylaws the words "sexual orientation," thereby banning discrimination against lesbigay doctors in its membership. In 1996, the AMA's Council of Scientific Affairs took a further step toward lesbigay equality by voting to rescind any support for attempting to "reverse" a gay patient's orientation, and stated simply that "The AMA believes that the physicians' nonjudgmental recognition of sexual orientation and behavior enhances his or her ability to render optimal patient care in health as well as in illness"(AMA CSA 1996).[20] Finally, many medical schools and residencies have chosen to publicly take a stand against anti-gay bias by incorporating sexual orientation into their non-discrimination policies, recruitment materials, and even into their physician's oaths.

## So, what are these attitudes?

The relationship between the medical profession and homosexuality is long and complex. Over the centuries, physicians' attitudes towards homosexuality have been informed in turn by religious leaders, politicians, medical researchers, and social activists. In this section, I will cast back into history several centuries, and highlight some of the earliest thinkers in the medical and scientific professions whose opinions have shaped medical thought and practice. While this may at first seem superfluous to the discussion of modern doctors' attitudes, the truth is quite the contrary. Virtually all current opinions can find their roots in the argument of previous centuries, and almost all of the earliest theorists still have proponents practicing medicine in today's hospitals, clinics, and academic medical centers. Finally, I will recount current attitudes of physicians toward homosexuality, as portrayed in approximately a dozen studies published in medical journals during the past three decades.

At various times in the past millennium, homosexuality has been viewed as a sign of moral weakness, an evil crime, an indicator of demonic possession, a lifestyle choice, and a biological inevitability. But it wasn't until the approach to the twentieth century that physicians stepped in to characterize homosexual behavior as an illness, per se. This section will address shifts in thinking on homosexuality through four distinct phases. For the earliest part of the millennium, the Church taught that homosexuals were abominable sinners. As the Church's control began to slip, political leaders took over to codify these moral imperatives into civil law, and sinners now became criminals. The eighteenth century saw the legal model begin to lose its grip as science gained power, and the

medical world explained homosexuality as an illness of identity, rather than simply a criminal choice. Finally, with the sexual revolution and the rise of the gay liberation movement, physicians were again challenged to reconsider homosexuality simply as a variation of normal, deserving of tolerance, respect, and study, rather than intervention and treatment.

*1. From sin to crime*

In terms of western medicine, sex was not a valid topic of medical research until the nineteenth century. As a result, the earliest physicians' attitudes toward homosexuality came by and large from the same sources as the general population's attitudes. Rather than contributing to the discourse on homosexuality, doctors simply adopted the prevailing societal attitudes as their own. It is important to note that at this time, "homosexuality" as it is known today did not exist. Instead, those suspected of same-sex activity were accused of such vague transgressions as "unnatural sex" and "sins against nature." Such violations were viewed as offenses against God, and therefore fell under the auspices of the Church. Religious leaders were responsible for imposing appropriate punishments, including prayer, special diets, and isolation[21] (p179). By the 1500's, warring Catholics and Protestants had divided the church's authority, and the church was beginning to lose some the control it had enjoyed for so long. The threat of hellfire and damnation no longer held the power it once did[22] (p34). Lawmakers stepped in to fill the void. These "criminalists" saw homosexual behavior as an immoral choice, similar to theft or murder. As early as 1533, "buggery," which may have included same sex activity, bestiality, and/or anal intercourse, was declared a felony in England under

Henry VIII. For three centuries to come, this statute was upheld, and at times was punished by hanging.[23]

*2. From crime to illness; science steps in.*

As the Enlightenment began to take hold in Europe, society was growing more secular, and its people were beginning to turn to science for answers to social problems. "Physicians, epitomizing the potential omnipotence of science, became the confidantes, consultants, and important thinkers influencing society."[17] In *The Construction of Homosexuality*, Greenberg argues a financial motive for physicians to medicalize previously viewed social ills, in order to increase their business.[24] Regardless of their motives, medical leaders made their mark on social stigma, as is evidenced by the 1852 "discovery" by Swedish physician Magnus Huss, of a new illness which he named alcoholism. "By calling heavy drinking a disease, Huss was reclassifying it as a condition that physicians should treat." In a medical journal, a nineteenth century physician took a familiarly paternalistic approach when he argued that "conditions once considered criminal are really pathological, and come within the province of the physicians. The profession can be trusted to sift the degrading and vicious from what is truly morbid." Naturally, some medical researchers began to turn their attentions to the persisting topic of homosexuality. A series of physician-researchers took a stab at explaining homosexuality by framing it not as a behavioral choice, like sin or crime, but rather as an illness.

In 1869, the first published case report of a homosexual (then referred to as "inverts," "perverts," or people with "contrary sexual instincts") appeared in a German

medical journal.[20] Within 15 years, no fewer than 20 similar reports were published in America, Britain, France, Italy, and Germany, ushering in a virtual explosion of study on the topic. Researchers enthusiastically dove into their patients' histories, eliciting family and medical histories, gender attributes, and of course, sexual experiences. The early case studies were characteristic of any new disease, and consisted mostly of detailed descriptions of the subject's symptoms and behaviors, supported by very little theoretical background. However, not all physicians were ready to accept this new way of thinking. A representative voice belonged to Dr. JA DeArmand, who expressed his opposition clearly: "Sexual perversion is the direct outgrowth of sexual abuse. It is the legitimate heritage of vicious associations and acquired weakness.... It surely is unnecessary to complicate medico-legal nomenclature by attributing such conduct to morbid mentality, when it clearly is deviltry...." But the groundwork had been laid; homosexuality, as it would come to be known, had entered into scientific scrutiny, and never again would it return completely to the darkness of the churches and the jails.

*3. Doctors begin debating.*

Classifying homosexuality, or "sexual inversion" as it was known at the time, as an illness caused a dramatic shift in thinking about humans as sexual beings. "In today's terminology, the medical experts had discovered that 'having sex' was not the same thing as 'sexual orientation' or 'sexual preference'."[18] Being gay, as we know it, was no longer just about *what you did*, but about *who you were*. Presented below are three representative physician-researchers whose works illustrate the major attitudes of physicians toward homosexuality from the last half of the nineteenth century through the

first half of the twentieth century: Dr. Richard von Krafft-Ebing, the author of the still circulating *Psychopathia Sexualis*;[25] Dr. Havelock Ellis, the father of Sex Research; and Dr. Sigmund Freud, the founder of psychoanalytic theory.

Richard von Krafft-Ebing (1840-1902) was a neurologist and psychiatrist in the nineteenth century whose collection of case histories, Psychopathia Sexualis (1886) became notorious for its unusually candid portrayal of "sexual abnormalities." His work clearly portrayed same sex intimacy and sexual acts as blatantly abnormal and "sick," an illness acquired through abnormal activity, particularly excessive masturbation. In fact, Krafft-Ebing viewed all non-procreative sex acts as "loathsome diseases." His volume of *Psychopathia Sexualis* was a bestseller in its day, and contained over two hundred case reports of sexual "deviancy" ranging from homosexual infatuations to harmless foot fetishists to portraits of sociopathic "lust murderers." Perhaps most disturbing about his work was that all these cases were presented as equally deviant. (Of note, the most recent edition of *Psychopathia Sexualis* was reprinted in 1999 and continues to be available on Amazon.com.) Because of his unequalled experience with deviancy, Krafft-Ebing was considered an expert in the field of homosexuality, and he was often called upon to testify in court, defending homosexuals against incarceration by explaining that homosexuals "were sick and therefore they should be treated therapeutically rather than punitively" (in Conrad).

In marked contrast to his peer Krafft-Ebing, Havelock Ellis (1859-1939), a proper British physician, held rather liberal views of sexual behavior for his time. A very forward thinker despite his Victorian upbringing, he introduced the radical idea that heterosexuality and homosexuality are not necessarily mutually exclusive, and may

instead represent a spectrum of sexuality. His writings on homosexuality encompass the two views that would take the stage in the coming years. In his 1897 publication, Sexual Inversion, he argued that most cases of homosexuality, rather than resulting from excessive masturbation as Krafft-Ebing had theorized, were innate. Also in contrast to Krafft-Ebing, Ellis insisted that such homosexuality is not inherently pathological. At the same time, however, he conceded that some cases may be acquired and that society had a right to prevent and punish such "inverts" (in Greenberg).

On the heels of Krafft-Ebing and Ellis came another neurologist who would influence medical thought on homosexuality for generations. Sigmund Freud (1856-1939) embedded his theories on homosexuality into a greater theory on human behavior. Like Krafft-Ebing, he viewed homosexuality as an acquired condition, but like Ellis, he also saw homosexual behavior as part of a spectrum. Rather than resulting from perverse behaviors like masturbation, Freud asserted that homosexuals are simply "arrested" in their normal development toward adult sexuality. This framing of homosexuality in relation to normal development was revolutionary, and supported Ellis's suggestion that homosexuality is not necessarily pathological, but can be simply a variation of normal. The implications of Freud's novel approach of tolerance toward homosexuality were vast. No longer was it necessary to punish, or even necessarily to cure homosexuals of their "afflictions". After all, according to Freud, all humans pass through such a stage on their way toward adulthood; some simply remain there.

Freud's writing on homosexuality were unlike any that had come before, and displayed not only his developmental views, but also a real compassion for the plight of homosexuals in his day. Perhaps one of the most abjectly nonjudgmental statements in

medical literature is contained in a letter to a mother who had written to Freud to express concerns about her son.

> "I gather from your letter that your son is a homosexual. … Homosexuality is assuredly no advantage but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function.... It is a great injustice to persecute homosexuality as a crime and cruelty too." (quoted in Herman)

*4. Toward a new health.*

Although physicians were dominating the debate in the first half of the twentieth century, they were not the only thinkers and writers on the topic. As followers of Krafft-Ebing, Ellis, and Freud debated the medical meaning and theoretical underpinnings of homosexuality (nature v. nurture, illness v. normal variant), an unassuming entomologist from Hoboken dropped a bomb on the world of sex research, and nothing would ever be the same again. In 1937, Professor Alfred Kinsey (1894-1956) a renowned expert in the study of gall wasps, and a respected family man, was asked to teach a new course to Indiana University's students on the topic of sex education and marriage[26] (p116). This simple request set Kinsey on a course which made him a target of ridicule, earned him the scolding of the AMA (Herman p48), launched him as a hero for gay rights activists, and would make him a household name associated with homosexuality for decades to come.

To prepare himself for teaching students about sex, Kinsey took the same methodical, statistical approach to the topic that he had previously mustered for his beloved gall wasps. During the twenty years he pursued his work on sex behavior,

Kinsey and his team collected sex histories from over 17,000 individuals, and published their findings in the landmark *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior of the Human Female* (1953).[27,28] Unlike his predecessors, Kinsey was relatively disinterested in the origins of sexual behavior; rather, he was first and foremost a scientist, concerned with carefully detailing, describing, and categorizing data. And particularly unlike Krafft-Ebing, Kinsey sought not just to document these stories, but to interpret them as data, and to draw conclusions about how common many previously viewed "deviancies" actually were. Furthermore, Kinsey presented his findings with a spirit of nonjudgment that none of his predecessors had managed to achieve. "This is first of all a report on what people do, which raises no question of what they should do, or what kinds of people do it." (Kinsey 1948 p7). Although his methods and figures would be criticized, the power of his findings - that 37% of adult white men and 13% of white women studied had "some overt homosexual experience to the point of orgasm between adolescence and old age" - could not be denied.

Despite Kinsey's assertions that homosexuality was natural, and was part of a spectrum of normal sexual behavior, the medical establishment was not convinced. Following Freud's death, a triad of his followers, Edmund Bergler, Irving Bieber, and Charles Socarides, psychoanalysts all, departed from Freud's earlier teachings of homosexuality as simply "a variation of the sexual function". Instead, they marshaled their collective resources to convince their medical colleagues not only that homosexuality was pathological, but that it was the medical profession's responsibility to develop and implement a "cure." At about this time, the American Psychiatric Association was formulating its first official listing of psychiatric disorders, the

Diagnostic and Statistical Manual, Mental Disorders (DSM-I) 1952[29], where homosexuality was classified among the sociopathic personality disturbances (quoted in Bayer[30]). The next two decades would see the debate ignite as Bergler, Bieber, Socarides, and their supporters squared off against the rising tide of homophile activists, and even gay psychiatrists themselves.

Concurrent to mainstream psychiatry's codification of homosexuality as a disease in the 1950's and 1960's, the seeds of the gay rights liberation movement were beginning to sprout. The year 1950, two years after Kinsey's controversial first book was published, saw the birth of the Mattachine Society, the earliest "homophile" organization whose mission was to integrate homosexuals into American society, followed shortly by the founding of the Daughters of Bilitis, its sister organization[31]. For the first time, homosexuals were organizing, and demanding to be heard. This unprecedented gathering of homosexual activists, together with the electrified political climate of America in the 1960's, resulted in several impassioned face-offs between the medical establishment and the fledgling gay establishment. Lacking allies from within the profession, activists began to target doctors, whom they saw as their tormenters. In 1968, gay activists leafleted the AMA National conference in San Francisco in opposition to a lecture by the prominent homosexuality-as-illness theorist Dr. Charles Socarides, demanding that proponents of a non-pathological view of homosexuality also be represented at future conventions (Bayer). In 1970, a lecture by Bieber was interrupted by an activist who jumped on stage, grabbed a microphone, and said "We've listened to you long enough; you listen to us. We're fed up with being told that we're sick. You're the ones who are sick. We're gay and we're proud." (as quoted in Herman). As a testament to the

influence of the activists, in 1971 the APA agreed for the first time in history to allow gay men and lesbians to publicly address a gathering of physicians to speak about themselves in a panel called "the Lifestyle of the Non-Patient Homosexual."

By the 1972 APA convention, activists had converged on a single demand: Homosexuality must be deleted from the DSM. They mounted a display at the convention called "Gay, Proud, and Healthy: the Homosexual Community Speaks" in order to raise support for their demand. Finally, in what could represent a turning point in the relationship between the homosexual community and the medical world, a gay doctor rose to speak. Dr. H Anonymous, as he was known, wore a mask, a wig, and an oversized cloak to disguise his identity as he addressed 500 of his physician colleagues, "I am a homosexual. I am a psychiatrist." He stated, "My greatest loss is my honest humanity. How incredible that we homosexual psychiatrists cannot be honest in a profession that calls itself compassionate and helping." (in Bayer) Many in the audience were stunned to hear that one of them was gay, and even more so to hear that more than two hundred gay psychiatrists were attending the conference with them. This was no longer simply an issue of "us" and "them"; it was now an issue of "us."

On December 15, 1973, the APA Board of Trustees voted 13-0 with 2 abstentions, to delete homosexuality from the DSM. Furthermore, they approved a sweeping statement in support of civil rights for homosexuals. It looked as though victory was in the hands of the activists. Bieber and Socarides, however, were not giving in. Opposition leaders lobbied for a referendum to be voted on by the entire membership of the APA. The board agreed, and in 1974, more than 10,000 psychiatrists cast their

votes. A majority of 58% supported the board's decision while 37% objected. While not an overwhelming validation of homosexuality as healthy, the tide had turned.

*5. Modern physicians' attitudes*

Although no longer technically considered "ill," lesbigay people now faced perhaps an even greater hurdle to health care: the attitudes of their health care providers. No fewer than two dozen studies have been published in the U.S., Canada, and the U.K. from 1969 through 1998, which examine the attitudes of physicians and physicians-in-training toward homosexuality. These studies reveal a large range of attitudes among doctors, varying greatly by sex, age, specialty and geographic region, and by when the study was conducted. The topic was of particular interest to the psychiatrists and to the generalists, who are most likely to interact with patients around the topic of sex. This section summarizes the findings of the best of these studies in three arenas: 1) attitudes toward homosexuality as a crime, an illness, and/or a sin, 2) attitudes toward homosexual physicians, and 3) attitudes toward homosexual patients.

*Attitudes toward homosexuality as crime, illness, or sin.* As discussed in the previous chapter, the medical profession's views toward homosexuality have undergone a series of changes through the years. Since the profession is comprised of individual doctors, it stands to reason the opinions of individual doctors will also have changed. The data suggest that while physicians by and large support basic legal rights for consensual homosexual behavior, a small number of them continue to believe that homosexuality itself is a sickness, although this number seems to be falling. The number of physicians who consider homosexuality a sin, however, is not changing, and these

physicians appear to be quite vocal with this opinion, perhaps because they view it less as a medical topic, and more as a moral one.

At the dawn of the gay rights movement, even physicians were in favor of basic legal rights for lesbigay people. In 1969, a Modern Medicine poll of over 17,000 practicing physicians asked "should homosexual practices be legalized?"[32] The majority of respondents in all specialties answered yes, with psychiatrists leading at 92%, and GP's, general surgeons, and orthopedic surgeons least in favor, with 58%, 58%, and 59% agreeing, respectively. At the same time, however, the debate over whether homosexuality was a *disease* raged on. While a 1973 survey of 210 British GP's and psychiatrists[33] found that only 6% of those surveyed viewed homosexuality as a disease, the division in America was much closer. Most vocal in the debate were psychiatrists and general practitioners (later to become family physicians), since they were the most likely to encounter issues of homosexuality in their daily practices. As documented in the previous section, the vocal and sometimes incendiary debate among the membership of the American Psychiatric Association reached some resolution in 1974 when the majority of members (58%) voted to support the Board's deletion of homosexuality as its own category in the DSM-III, while over a third (37%) opposed removing it.

However, a vote alone did not change the attitudes of the dissenters, and it's not clear what effect if any it had on the general physicians' attitudes. Unfortunately, once the APA's vote passed, it seems the topic fell out of interest for the research community, and homosexuality as a disease was not raised again for many years. Another British researcher, Bhugra, in 1996 surveyed 351 psychiatrists and GP's, and found that only 7% agreed that homosexuality is an illness.[34] The difference between the two studies was that

while Morris found that psychiatrists were twice as likely to agree that homosexuality is an illness as compared to GP's, Bhugra found exactly the opposite. Next, Oriel surveyed 291 family medicine residency directors responded to a questionnaire on homosexuality. Again, 6% agreed with the statement "homosexuality is a mental disorder," curiously echoing the results of the previous two British surveys.

While the data suggest that there may have been movement away from viewing homosexuality as an illness, it's not clear whether there has been similar change in viewing homosexual behavior as sinful. Although fewer data are available for this question, religious beliefs have manifest themselves in several publications on the topic. Take, for example, an editorial published in the Southern Medical Journal in 1994,[35] where a physician put forth his belief that homosexuality was an intrinsically unhealthy lifestyle, and he quoted biblical passages from the New Testament to support his views. In a New York study of AIDS anxiety among Health Care Professionals, Wallack[36] found that a shocking 9% of respondents, including 5% of physicians agreed with the statement "AIDS is God's punishment to homosexuals." Gemson's 1988 survey of almost 500 New York City internists, OB/GYNs, family physicians, and general practitioners[37] found that 36% agreed that "homosexual behavior between two men is just plain wrong." In Oriel's survey of Family Practice residency directors, 22% agreed that "homosexuality is a sin."

In summary, many modern physicians are continuing to hold to tenets that their predecessors for centuries have believed. A small and shrinking minority maintains the belief that homosexuality itself is a sickness, and should be criminalized, and a small but

steady minority continues to invoke the name of God to explain their objections to lesbigay people.

*Attitudes toward homosexual physicians.* This topic has been addressed in the literature in two ways: First, whether homosexuals should be allowed into the profession, and secondly, how are gays in the profession to be treated. The most dramatic and consistent findings in the data are as follows. Opposition to homosexuals in the profession, while present, appears to have decreased quite dramatically in the past three decades. Next, the opposition varies greatly depending on the specialty of the doctor surveyed, and on the chosen specialty of the gay physician. Finally, lesbigay physicians themselves have actually begun to speak out about their experiences.

The question of admitting lesbigay people into medical school has been asked at least three times in the past two decades. The first questionnaire to address the topic was distributed in 1982 by Mathews to over 1000 members of a California medical society. He found that one in three respondents (29.7) would refuse medical school admission to a "highly qualified homosexual applicant." Most opposed were orthopedic surgeons (49%) and general and family physicians (36.3%), and least opposed were psychiatrists (9.2%) and pediatricians (18.4%). The same question was asked of 117 family practice residents in the same geographical region five years later, and the results were dramatically different. While in Mathews' study more than a third of family physicians opposed admission, only one in ten residents in Prichard's study (10.8%) would block a gay or lesbian applicant. This suggests that those physicians who are further out of training are more likely to oppose lesbigay people in the profession. Finally, the most recent survey asked over 1000 practicing physicians in New Mexico the same question in 1996

(Ramos). While the specialty breakdown was not provided, only 4.3% of all respondents would refuse admission to lesbigay applicant. Again, this supports the theory that physicians who are earlier into their practice may be less opposed to lesbigays in medicine than their predecessors were.

A related article appeared in the March edition of the North Carolina Medical Journal[38]. The piece, entitled "Gays, Lesbians, HIV Infection, and Admission to Medical School: A Physician's Roundtable" invited three admissions committee members from two southern medical schools for a discussion, despite the editor's admission that "One dean ... actively discouraged us from pursuing these questions, saying we shouldn't be looking for trouble." All three respondents asserted that a student's disclosure of his or her homosexuality would not influence their admissions decision, either positively or negatively: "that fact would not affect my evaluation of the candidate's fitness for admission," "I do not believe that the disclosure would prejudice me (or my colleagues) against the candidate to any significant degree," and "I would expect no systematic effect on the decision-making process of the committee." At the same time, each made it clear that they did not believe sexual orientation was an "appropriate" topic for such an interview, and one noted that "in nearly six years on the committee, I cannot recall any applicant disclosing a gay or lesbian preference." Inherent in this discussion was an unspoken discomfort of the topic of homosexuality, and an agreement that such talk would not be advisable in the context of a medical school interview. However, since a primary purpose of the interview is to give the applicant an opportunity to ask frank questions about the medical school which might help the applicant choose the best school, (which for a gay student might include such questions as "does the school offer

partner benefits?" or "is there a support group on campus for gay and lesbian students and residents?"), the committee members' discomfort on the topic and their assertion that it's not an appropriate topic could be interpreted by qualified applicants as rejection, and might make them less willing to attend that campus.

Medical training does not end with graduation from medical school, however. Residency training is the next necessary step to becoming a physician, and studies have shown an alarming amount of opposition to gays and lesbians seeking residency training. Mathews was the first to describe this opposition when he asked "whether homosexual physicians should be discouraged from seeking residency training" in specific specialties. He found considerable variation by both the respondent's specialties and by the residency training being sought. Overall, respondents were least opposed to gay doctors training in specialties with little patient interaction (pathology 11% and radiation therapy 13.4%), and were most opposed to gays in specialties dealing with children or emotional problems (pediatrics 45% or psychiatry 39%). However, when broken down by respondent's specialties, some dramatic differences are revealed. While gay doctors seeking training in radiology seemed to face the least opposition (11% overall), it was the pathologists and radiologists themselves who were most opposed to gays in their own professions (24.4%). At the same time pediatricians themselves, along with psychiatrists and internists, were the least opposed to gays seeking training in pediatrics, while more than half of orthopedic surgeons, pathologists, and general and family practitioners were opposed to homosexuals in pediatrics. Ramos' 1996 survey which asked the same questions of practicing physicians in New Mexico reported a dramatic decrease in the percentage of respondents opposing trainees in all fields, from a range of 11% opposing

radiology and 45% opposing pediatrics in Mathews' study, down to a range of 4.3% opposing radiology and 10.1% opposing obstetrics-gynecology. While there was no breakdown of responses by specialties, Ramos found that overall, pediatricians were least likely to oppose gay trainees in their own field, while surgeons and obstetricians were the most likely (16.2% and 12.1%, respectively).

Since members of a specialty choose their own trainees, among the most sobering findings of these studies is that significant numbers of specialists are strongly opposed to homosexual trainees within their own fields. In Mathews' study, one in four pathologists and radiologists, and over one in five psychiatrists would opposed gay trainees in their own specialties, and in Ramos' 1996 survey, one in six radiologists and pathologists, and one in 8 obstetricians continues to feel the same way. These data suggest that there may be reason for gay medical students to conceal their identities when interviewing for residency positions in selected fields.

The final and perhaps most disturbing of Mathews' findings concerned patient referrals to physician colleagues. Respondents were asked, "Suppose you learned that a physician-colleague is a homosexual. Would you continue to refer your patients to this physician if he or she worked in any of the following specialties?" Mathews found that almost half of those surveyed (46.3%) would discontinue referrals to gay pediatricians, 42.9% to gay psychiatrists, a quarter to gay surgeons (25.4%), and almost a fifth to gay radiation therapists (18.6%). Similar patterns to the previous questions emerged when respondents' specialties were considered. Again, surgeons and radiologists were most likely to discontinue referrals to any known homosexual, including those in their own specialties, while psychiatrists, pediatricians, and internists were least likely to

discontinue referrals, including to gay doctors in their own fields. General and family practitioners as a specialty were the most likely of all, after radiologists/pathologists, to discontinue referrals. About half would stop referring to a gay pediatrician or psychiatrist, a third to a gay surgeon, and 3 in 10 wouldn't even refer to a gay radiation therapist. Prichard's 1986 survey of family practice residents in southern California found that while they were less likely to discontinue referrals than those in Mathews' study, almost 30% would stop referring to a gay pediatrician, and a fifth to a gay surgeon or psychiatrist. Notably, however, a full quarter would stop referral to a gay family medicine colleague. Unfortunately, neither Mathews, nor the researchers who followed, ever asked "why" respondents would discontinue these referrals.

Ramos' findings from 1996, again were quite different. Of note, the decade and a half that passed since Mathews' landmark study saw the rise of AIDS as a clinical entity, which may have contributed to the changes between the two studies. Oriel found that only 6% to 11.4% of physicians would discontinue referrals to a colleague, with the discontinuations most likely to obstetrician-gynecologists, urologists, and pediatricians, and least likely to radiologists. When broken down by specialties, again Ramos found that general practitioners were most likely to discontinue referrals to gay doctors, particularly to surgeons (20%), as were surgeons themselves (14%).

The importance of these data cannot be overemphasized. Particularly in today's managed-care environment, it is the primary care provider, most often a family physician, internist, pediatrician, or obstetrician-gynecologist, who is responsible for referring their patients to other specialists. The power held by these "gatekeepers" is enormous. The studies by Mathews, Prichard, and Ramos have dramatically demonstrated that many of

these primary care providers, particularly the family physicians and obstetricians, are decidedly less likely to refer their patients to a colleague they know is gay. Again, this suggests that gay physicians who choose to reveal their sexual orientation could be jeopardizing their professional futures.

Gay and lesbian physicians have to struggle not only against the attitudes of their colleagues and supervisors, but also against the attitudes of their patients. One telephone survey of 800 Americans conducted by Time Magazine in 1994 suggested that over 60% of patients would refuse to see a gay doctor.[39] To date, however, only one scientific study has looked systematically at the attitudes of patients toward lesbigay physicians. Conducted in 1995, Druzin's study surveyed 346 adults in greater Montreal about their willingness to see a gay or lesbian family physician.[40] The overall prevalence rate of discrimination based on sexual orientation was 11.8% (95% confidence interval 8.5% to 15.1%). A sensitivity analysis taking into account the refusal rate suggested that the actual figure might be as low as 8.2% or as high as 38% (if all non-responders were all discriminators). The most common explanations for refusing to see a gay doctor were that the subject would feel "uncomfortable," or that gay doctors are "generally incompetent." Only a small minority of respondents gave reasons as "fear of being thought of sexually" 5%, "fear of being sexually harassed" 10%, or "fear of contracting AIDS or other STD" 10%. The authors found at the same time that discriminators were more common among older people, and were more commonly men than women. These findings offer real concerns for lesbigay physicians who are considering being open about their sexuality.

*Attitudes toward homosexual patients.* Researchers in the past three decades have taken a wide variety of approaches to measuring attitudes toward homosexuality. These attempts have ranged from simple yes/no questions like "Do you think homosexuality is an illness?" to 25-item Likert-type scales testing reliability and validity. Still others have taken a more qualitative approach, interviewing subjects at length about their thoughts and feelings on the topic of homosexuality. In fact, in 1993, Schwanberg identified and analyzed a total of 45 studies published from 1971 to 1987 which assessed attitudes toward gay men and lesbian women.[41] Despite the different instruments used, populations tested, and approaches taken (cognitive v. affective assessment), several common themes emerged, many of which will be addressed in this section. While the literature contains a great deal of information on attitudes of college students, and attitudes of other health care providers (including nurses and psychotherapists), for the purpose of this project only the studies which directly assess attitudes of physicians or physicians-in-training will be considered. To chronicle how views may have changed over years, the studies are presented in chronological order.

Early researchers in the medical field attempted to measure attitudes rather directly, simply asking about comfort levels in treating homosexual patients. The findings were not surprising; a large minority of physicians felt uncomfortable treating gays. In 1970, Pauly published findings from a survey of 900 Oregon physicians, where almost half of the respondents (48%) acknowledged feeling some discomfort in treating a patient who "appears" to be a male homosexual.[42] At the same time, only 15% of responding physicians acknowledge having attitudes that adversely affected treatment of male homosexuals, while they attribute 35% of their physician colleagues to hold such

attitudes. A 1978 American Medical Association survey (Golin) of over 200 physicians found that over a third of doctors (35%) report feeling uncomfortable treating homosexual patients.

With the emergence of AIDS as a "gay disease" in the 1980's, health care workers had a whole new reason to be uncomfortable around gay patients. At the same time, the devastation wrought by the disease spurred a great deal of research, including inquiry into the relationship between the medical establishment and lesbigay patients. A number of scales were developed to measure what was becoming known as "homophobia," fear of or discomfort with homosexual people. Notably, the HATH (Heterosexual Attitudes Toward Homosexuality) Scale[43], the IHP (Index of Homophobia)[44], and the Homophobia Index[45] were multi-item Likert-type scales applied by medical researchers to gain insight into the attitudes of doctors at various levels of training.

Mathews' 1982 survey of over 1000 California physicians, distributed just before the AIDS epidemic had taken hold, asked "How do you feel about treating homosexual patients?" In a finding that was parallel to Golin's study, a large minority (39.7%) of physicians were "sometimes" or "often" uncomfortable treating homosexual patients, while 60% reported "no negative feelings." Using the HATH, a 25-item Likert-type scale which categorizes respondents as homophobic, neutral, or homophilic, Mathews found that 37% scored in the range of homophilic, 40.1% as neutral, and 22.9% were homophobic. When stratified by sex, age, and specialty, Mathews found significant differences. Women were more likely to give homophilic responses than men (50.7% v. 35.7%), as were more recent graduates compared to older graduates. The majority of psychiatrists and pediatricians gave homophilic responses (62.3% and 56.4%), while only

one in five surgeons (20.4%) did. Almost a third of orthopedic surgeons scored in the homophobic range (32.0%), followed by obstetrician-gynecologists and general practitioners/family practitioners at 31.4% and 31%, respectively.

A 1983 survey by Douglas of 128 residents and nurses at a large NYC teaching hospital measured attitudes using a similar scale, the IHP.[46] Both the physicians and nurses scored in the low homophobic range, at 50.84 for physicians and 55.6 for nurses. (Scores on the IHP range from 21 to 100, with scores of 50 or above defined as homophobic.) Unlike in Mathews' study, the females scored significantly more homophobic than the males. No significant differences were found by age, religion, or number of years of professional experience. In response to the statement "homosexuals who contract AIDS are getting what they deserve," 11 of 90 nurses (12%), but only 1 in 37 physicians (3%) agreed. In 1986, the researchers repeated the study[47], expecting to find "a worsening of prejudice give n the intense and often frustrating and depressing nature of sustained day-to-day contact with AIDS victims." However, their repeat survey of 25 residents and 52 nurses found a trend toward lower IHP scores (47.4 v. 50.8 for physicians, and 51 v. 55.6 for nurses). This time, no significant difference was found between men and women. Again, only one physician in the 25 (4%), and just 4 of the 52 nurses (7.7%) agreed that gays who get AIDS are getting what they deserve, no significant change from the earlier study.

In 1985, Wallack conducted a similar study on AIDS anxiety among health care professionals in New York City. His survey of 67 resident physicians and 172 nurses also found a great deal of hostility toward lesbigay patients, and particularly toward patients with AIDS. Almost half 48 of all respondents acknowledge "feeling angry at the

homosexual population and blamed homosexual promiscuity for causing an epidemic that now threatens the heterosexual population." Eighteen percent of doctors agreed that gay men with AIDS have only themselves to blame, and 5% of doctors agreed that "AIDS is God's punishment to homosexuals." One fifth of physicians admitted that they show some discrimination in their ability to deliver health care to homosexuals.

Medical student attitudes toward homosexual patients were first assessed by Kelly, in his 1987 study of 119 second and third year Mississippi medical students[48]. In this creative study, students were randomly assigned one of four vignettes for a patient named Mark, and asked to report their responses to the patient. The four cases were absolutely identical except for two variables: his disease was presented as either AIDS or leukemia, and his partner's name was identified either as Robert or as Roberta. The authors found that students harbored surprisingly negative views of homosexual patients, regardless of their illness, and negative views of AIDS patients in particular. Students were significantly less willing to converse, even in a casual manner, with a homosexual patient than a heterosexual patient; they perceived homosexual patients as more responsible for their illness; and they perceived gay patients as suffering less pain than the straight patients with the same disease. The multivariate analysis of variance of responses on the interpersonal attraction inventory showed that students described the homosexual patients as significantly "less appropriate, more offensive, less truthful and less intelligent" than their heterosexual counterparts. The authors did not look at differences based on gender or religiosity, and did not address whether their region (Mississippi) may have accounted for some of the severity of anti-gay findings.

Three years later, McGrory repeated Kelly's study with 103 Columbia University third year medical students in New York City[49]. In marked contrast to Kelly's findings, he found no significant differences between group responses to the four vignettes. Unlike the Mississippi students, "students at P&S at a similar point in their training did not exhibit a negative attitude toward homosexuals, although they did express negative feeling towards AIDS patients." The authors attribute the differences between their findings and Kelly's to possible "different environments and influences" and suggested that "interventions in the medical school experience can address prejudice and bring about more humane care."

The HATH questionnaire was implemented again in Prichard's 1988 study of 117 family medicine residents training in Southern California. These doctors were younger and earlier into their training than those in Mathews' original study, so the finding that many more residents scored homophilic than the previous study was not surprising (62.4% v.37%). Prichard's findings agreed with Mathews in that women were significantly more likely to score homophilic than men. A slightly higher percentage of respondents than in either of Kalman's New York surveys agreed that gays with AIDS are getting what they deserve (5.1% v 3% and 4%).

Homophobia among 101 psychiatric residents, family practice residents, and psychiatric faculty in Ontario, Canada was the topic of a 1991 publication by Chaimowitz.[50] While the mean IHP score for each group fell in the low-grade non homophobic range, about a third each of psychiatry residents and family practice residents score in the homophobic range (33% and 36%), while a quarter of faculty members scored in the homophobic range (25.8%). These figures were lower than those

reported by Douglas for his two studies of New York City residents. When asked "Do homosexuals with AIDS get what they deserve?," 4.2% responded yes, a figure very similar to the previous studies. (Table 1)

**Table 1: Percentage responding "yes" to "Do homosexuals with AIDS get what they deserve?**

| | Year | N | Population Studied | % say yes |
|---|---|---|---|---|
| Kalman | 1985 | 138 | NYC MD's | 4.0 |
| Douglas | 1987 | 146 | NYC MD's | 3.0 |
| Prichard | 1988 | 117 | Family Medicine Residents | 5.1 |
| Wallack | 1989 | 67 | NYC house staff | 5.0 |
| Chaimowitz | 1991 | 101 | Psychiatry Residents, Faculty | 4.2 |

In 1994, Oriel surveyed the directors of family practice residency programs in the U.S. to assess their attitudes toward homosexuality. Using the HATH scale, of the 236 respondents, 67% scored in the homophilic range, 25% scored "neutral," and only 8% scored homophobic, the lowest score yet published for the HATH score among physicians. Those directors who scored in the homophobic range offered narrative comments, "describing homosexuality as a mental disorder, a 'genetic defect...psychiatric diagnosis... an aberration' or likened homosexuality to 'alcoholism, adultery, fornication, dishonesty, theft, etc.'"

To summarize these dozen studies, spread over three decades, conducted with medical students, residents, practicing physicians and academicians, from southern California to New York City and from Oregon to Mississippi, is daunting. However,

several trends emerge which bear recounting. First, of six studies to find a difference in attitudes based on gender, five of them found that women hold more positive views toward homosexuality than men. Next, three studies suggest that physicians or physicians in training who have a gay friend or relative, or have interaction with a gay colleague are more likely to have positive attitudes toward lesbigays. Third, findings from more recent studies consistently find more positive views toward homosexuality than studies from previous years. Fourth, real differences exist among specialties in terms of attitudes toward homosexuality. Finally, there seems to be a small but persistent minority (approximately 3% to 5%) among all residents and physicians who hold on to the belief that gay patients with AIDS are getting what they deserve, or that AIDS is God's punishment to homosexuals.

### *Section II: The Gay Doctor*

Since the 1960's, researchers have made great advances in our understanding of the attitudes of physicians toward lesbigay patients and colleagues. However, the personal experiences of lesbigay physicians and medical students themselves have remained almost entirely unexplored in the medical literature. Volumes of books recount the stories of lesbigay artists and authors and historical figures. Dozens of papers and book chapters tell the tales of lesbigay professionals: priests and nuns, teachers, librarians, athletes. One book traces the line of lesbigay graduates of the Harvard Business School from the 1940's to today[51], while a law journal devotes an entire issue to the topic of Sexual Orientation and Law Education[52].

At the same time, the medical literature is replete with the tales of other minority medical students and physicians over the years: the earliest female medical students; biographies of prominent minority physicians. Yale itself boasts two medical student thesis projects on minorities at Yale School of Medicine. Although African American students had attended Yale since 1854, their story remained untold until Daryl Daniels put it to paper in 1991[53]. And the entertaining story of how a ladies restroom (or the lack thereof) almost prevented Yale's first female students from joining was told in Susan Baserga's 1983 thesis[54].

So where are the lesbigay doctor's tales? It is the physician who defined homosexuality, who pathologized homosexual acts and identity, and who is expected to be the healer of the 'sick'. Why has this story not been told?

## Stories

In large part, the stories have not been told because the storytellers feared losing their jobs. Throughout the past three decades, lesbigay doctors have encountered the same dilemma again and again: the desire to be open with their colleagues and patients about their identity, the discomfort and pain caused by the overt homophobia and covert ignorance of their colleagues and patients, and the fear of losing respect, patients, and even their very livelihoods if they do choose to come out. At the same time, the number of doctors who are choosing to come out is increasing, and their stories have become increasingly encouraging. Some have coped with the fear of backlash by publishing as "anonymous", or by presenting to peers in a disguise. Others, especially in more recent

years, have proudly signed their names to letters and sat for photos to accompany their works. Over a dozen of these tales from the medical literature are recounted below.

In a touching, anonymous letter to the Editor of the New England Journal of Medicine in 1970, an intern writes, "I am homosexual.... I look forward to the day when I can ... sign my name to a letter such as this."[55] Perhaps the first public appearance by a lesbigay physician took place at the 1972 American Psychiatric Association annual convention in Dallas (Bayer). "Dr. Anonymous," a psychiatrist in a disguise, addressed hundreds of his colleagues by taking part in a panel on homosexuality. He told the surprised assembly that there were no less than 200 gay psychiatrists joining them at the convention.

A year later, Dr. Howard Brown, the chairman of the board of directors of the New York City Public Health Association, found himself of the front page of the New York Times for his declaration of homosexuality[56]. It is the first well-documented public "coming out" of a physician. He had known he was gay since before medical school; he even tried discussing the topic in 1943 with "the aging chairman of the department of psychiatry at the medical school. He told me I couldn't possibly be homosexual. I was going to become a doctor, wasn't I? Homosexuals didn't become doctors." (p35) But when he was invited to address a gathering of physicians at a symposium on human sexuality, he jumped at the chance. "If I had publicly announced my homosexuality in 1968, ...I would have found little understanding, and even less support. I would probably have had to commit suicide the next day. By 1973, such a thought was wildly out of date: both the attitudes of homosexuals toward themselves, and the public's attitude toward them had changed." Taking the advice of the symposium organizer, he began his

address by first establishing himself as "just another doctor," recounting his medical education at Western Reserve, his internal medicine residency in Detroit, and his current public health work in New York, before launching into the truth. "'I was invited here not as a medical scientist but as a homosexual. I am publicly announcing my homosexuality in the hope that it will help to end discrimination against homosexuals.'... The doctors applauded.... I emerged from the dark auditorium to find myself facing ranks of television cameras."

Candid stories such like Dr. Brown's are extremely rare, even today; gay physicians continue to keep a very low profile. A thorough search of Medline, as well as the medical school library using keywords "homosexual," "gay," "physician," "doctor," and "medical student" yielded few additional stories, none of which were published before the 1990's. An example where a physician openly wrote about his own sexuality in a major medical journal occurred almost two decades after Dr. Brown dropped his bombshell. In 1992, Charles R. Fikar, a pediatrician practicing in New York, wrote a letter to the editor of the Western Journal of Medicine[57]. In this letter, he took issue with the author of a study on medical student harassment[58] for not including anti-gay acts and statements in the study. The study had included other targeted types of mistreatment, including racial and sexual harassment. Fikar criticized the study's authors for "the conspiracy of silence and the unwillingness to acknowledge the presence of gays in medicine," and he testified to his own experiences of abuse as a medical student. "Gay health professionals may be exposed to homophobic snide remarks, snickers, and derogatory comments and gestures. These I have personally encountered, a result of which I have felt hurt, anger, resentment, fear, humiliation, and embarrassment; in short, I

was abused." He concluded by writing "I am happy and proud of my gayness... I will not be silent."

Although Fikar was content to be "out" to the medical community through his publications, he shared his ambivalence toward being completely open at work in a later publication that same year[59]. "I feel within me the yearning to be openly gay in my clinical practice so that all my patients who need a gay role model or an adult gay person with whom to share feelings may feel free and secure to do so. I do not feel totally comfortable in doing so at this stage of my life. I worry about the possible negative and hostile reactions of some of the other professionals and co-workers at the health centers where I practice, as well as the reactions of the parents of my patients. The publication of this report is actually one step for me in my own coming-out process."

The year 1992 also saw the publication of a novel by an erstwhile Yale medical student.[60] Martin Schecter writes a touching coming-of-age and coming-out story about his year as a Yale medical student. Pressured into attending Yale by his high-achieving physician father, Schecter struggles to integrate his artistic, expressive, gay self with the dehumanizing and alienating world of medicine. "I didn't want to be GAY," he laments. "I wanted to be NORMAL... If I was gay, how would I ever be successful (article in print in the New England Journal of Medicine)." His decision to drop out of medical school and explore his own life more deeply makes for a moving story.

In 1994, two medical students "came out" of the closet to the entire medical profession by contributing pieces to Pulse, the Medical Student Section of JAMA. Anthony Geraci, a gay medical student in New York, shared his struggle over whether or not to wear his trademark earrings on the wards, and the conflict his choice caused

between him and a gay classmate[61]. After being cautioned by her advisor not to disclose her lesbianism on her medical school applications, Lydia Vaias arrived at medical school, and "understood the truth behind her my advisor's warning."[62] She was confronted with homophobic jokes, cartoons, and graffiti, both among her classmates, and from her superiors. Discouraged, she decided to submit a piece to JAMA about her experiences. "What has been most disappointing is that I was expecting better of medical students and faculty… I hope that by being honest and visible I can help others understand us better and give lesbian and gay young people the message that they can survive intact and aspire to their dreams."

In 1996, the Canadian Medical Association Journal devoted its cover story to "Medical students seek to overcome 'invisibility' of gay patients, gay issues in curriculum."[63] The article profiled two lesbigays: a faculty member and a medical student. Dr. Gary Gibson, a professor of family medicine, "went many years without identifying a single gay patient in his practice. When he 'came out' about his homosexuality in 1981, about 15 of his patients revealed they were gay." In contrast, Ron, a gay medical student [not his real name], recounted a woeful encounter with his family physician. Having just started a new relationship, he went to see his doctor about an HIV test. "But when he mentioned in passing that he was gay, he got more than he bargained for. His physician spent the next 40 minutes expressing his views on religion and homosexuality." The year was 1995.

Perhaps the most poignant publication about the experiences of lesbigays in medicine featured nine Canadian medical students and residents[64]. Five of the interviewees chose to use their full names, while the remaining four declined, "I would

like to be able to use my name for this article and not have to worry about the consequences." Their common experiences are striking. Most recall hearing stories of homophobic remarks at the hands of classmates and superiors, and they all express fear of discrimination. Where they differed greatly was in their choice whether and how to disclose their sexuality to their colleagues. Dr. Jill Tinmouth 'vowed to be out from day one', and Kevin Speight came out to his classmates by taking a date to the orientation-week dance. One student wears a rainbow flag on his stethoscope to identify himself to gay patients. Others take a stepwise approach, starting by finding other lesbigay classmates or residents, telling a few friends, and perhaps a sympathetic faculty member. Others simply avoid all talk of personal life. "Tony [an anesthesia resident, not his real name] won't lie about his orientation. He simply avoids discussing his personal life at work." A surgical resident who asked that her real name not be used reveals how her secrecy about her personal life has hurt her career. "The professional relationship is improved by being able to disclose personal information about yourself, and as a closeted resident, I was at a disadvantage to develop more of a relationship with my staff physicians because of the homophobia I saw in them."

What is particularly encouraging about these stories is the apparent success of the students who have chosen to be the most out. They acknowledge no discrimination as a result of their disclosure, and they emphasize the satisfaction they derive from being able to serve as a role model for other lesbigays.

> *"I've had a very positive experience here... I was elected class president in my second year with the full knowledge of my classmates that I was gay. I was elected medical student society president in their year, again being quite open*

*about my sexuality. ... The same year, a closeted upper-year student sought my advice on coming out and thanked me for being an inspiration."*

*"It's important to have gay and lesbian physicians, so that people are exposed to us in medical school and as colleagues and we're there as resources... I can't be a resource and role model if I'm closeted."*

*"I've even had attendings here tell me that they feel my life experience has contributed positively to my approach to medicine and to my approach to patients.... That's pretty amazing."*

## Studies

Very few publications have attempted to systematically describe the experiences of lesbigay doctors. Those that have fall into three categories. First, two studies quantified harassment experienced by lesbigay physicians and medical students. (As recounted in the previous section, lesbigay physicians also suffer discrimination at the hands of their colleagues, many of whom studies show will discontinue referrals to doctors they think are gay. In addition to the harassment and ostracism physicians suffer at the hands of their colleagues, the previous section also presented a study that suggests that patients too will discriminate again lesbigay physicians. These studies will not be re-presented here.) Next, two studies document support services for lesbigay students offered by U.S. medical schools. The third category encompasses unreleased studies from Yale School of Medicine's Committee for Well-Being of Students (CWBS).

The largest study to date looking at the experiences of lesbigay physicians was conducted by the Gay and Lesbian Medical Association, which surveyed 711 lesbigay

physicians and medical students from 46 states. The major findings of the study include the following: A majority (59%) of respondents indicated that they have been ostracized, harassed, or discriminated against within the medical community because of their sexual orientation, and a shocking 14% has been the victim of "gay-bashing."

The Lesbian Harassment study conducted by Donna Brogan, although it limits itself to lesbians alone, has a major advantage over the GLMA study[65]. Brogan conducted an analysis on a subset of data from a huge nationwide study (The Women Physicians' Health Study) of over 10,000 women physicians. As a result, her sample reaches even those lesbians who choose not to affiliate with any lesbigay organizations. She identified 115 women who either called themselves lesbian or reported current sex with women. Self-identified lesbians experienced "sexual-orientation-based harassment in a medical setting" at the alarming rate of 41%, while the lesbians and heterosexual women both reported similar prevalences of gender harassment (approximately 50%) and sexual harassment (approximately 40%). While these data cannot be generalized to gay or bisexual men or to bisexual women, the numbers confirm that sexual orientation-based harassment is terribly common in the medical setting.

In 1991, Townsend published a study of support services for lesbigay medical students, and found them sorely lacking[66]. Most students surveyed reported a "fear of being openly gay" (56%). Students at private medical schools were more likely to have access to a gay student group than those at public schools (67% v 50%). When asked how the medical school experience could be improved for gay and lesbian students, 31% stated they wished an increase in the number of openly gay and lesbian faculty, and 20% offer official support to homosexual students. When they repeated and expanded their

survey in 1994,[67] they found that 62% of the 185 lesbigay medical students surveyed reported exposure to anti-gay comments, and a disturbing 15% indicated they would not choose again to enter the medical profession. Most students had told a classmate (91%) and a faculty member (67%) they were gay, but less than half said they were out to the whole class (44%). The authors found that those students who had more institutional support were more likely to come out to classmates and faculty, and were more likely to know faculty they could talk to about lesbigay issues.

Each year, Yale's student-run Committee on Well-Being of Students surveys the student body about various topics, including safety, racial and sexual harassment, financial aid. For the past several years, three questions have also been included to assess mistreatment based on sexual orientation. Data from three years were made available: 1996, 1998, and 1999.[68] Response rates for the survey improved from approximately a quarter in the first year to almost half in the final year. Of all 453 respondents, a total of 23% report witnessing "offensive remarks about homosexuality directed at others" (not specified patient v. colleague). When separated by pre-clinical and clinical years, the rate rises to almost a third of students on the wards have overheard anti-gay comments, suggesting that the longer one stays in the medical school environment.

In addition to witnessing offensive remarks, students also report being the recipients of such remarks. Three percent of students have been the target of offensive remarks about sexual orientation, and less than one percent (3) of the 453 students say they have been denied opportunities because of their sexual orientation. Given that lesbigay students made up an estimated 3% to 6% of the student body, they might have comprised 14 to 28 of the respondents. In that case, as many as 20% of lesbigay students

might have been subjected to discrimination based on sexual orientation, and the majority of them may have actually witnessed anti-gay remarks.

In summary, gay doctors exist, at Yale and in the medical profession at large. They experience harassment and ostracization from their colleagues at alarming rates, and many live in fear that if their true identity were known, their careers would be ruined. Medical schools are doing little to provide support to these students, and medical training itself serves as rude introduction to the homophobia of medicine for many lesbigay doctors in training. At the same time, the 1990's has witnessed lesbigay doctors coming out in unprecedented numbers, and sometimes even to praise and cheers. Out gay doctors have even begun to be seen as a valuable resource, with a unique perspective to offer to the medical team and to patients.

## STATEMENT OF PURPOSE

This project is intended to broaden the base of medical knowledge in two areas: the attitudes of physicians toward lesbians, bisexuals, and gay men (hereafter, "lesbigays") past and present; and the unique experiences of lesbigay physicians, in their professional and personal lives. This goal is accomplished by an extensive review of existing literature, together with original data gathered from graduates of the Yale School of Medicine, and publications of the school. This knowledge may then be applied to inform medical school curricula, or in continuing medical education.

## METHODS

In accordance with the guidelines for research involving human subjects from the Human Investigation Committee, a study protocol was developed and submitted in April 1999. After revisions to change the title and to clarify the introductory paragraph, it was approved on July 7, 1999 as protocol #11050. (Appendix A)

The list of subject names and addresses was obtained from Ralph Nardi in the Development Office, and consisted of all graduates of the Yale School of Medicine from 1969 through 1998 for whom a mailing address is known. Approximately 2,720 subjects were contacted. Using a modified Dillman Method, each subject was sent three separate first-class mailings through the U.S. Postal Service[69]. (Appendix B)

The first mailing was sent in November 1999, and consisted of an introductory letter describing the study and inviting participation, an anonymous questionnaire form, and an unmarked stamped return envelope. The content of the questionnaire form is addressed in the next section. In addition, each mailing contained a stamped Coded Response Postcard for the purpose of recording who had completed the questionnaire, while maintaining anonymity in responses. Subjects were instructed to fill out the questionnaire and put it in the stamped envelope provided, sign the postcard, and mail each separately. This design, as suggested by Dillman, allows the subject to return two items separately - the questionnaire, which is unmarked, and a postcard, which is coded. Using this technique, the principal investigator is able to identify which subjects have

completed the questionnaire while still maintaining anonymity in the questionnaires themselves.

The second mailing was sent two weeks later, and consisted of a reminder postcard and thank you note. The third mailing was sent only to those subjects who did not return a Coded Response Postcard. It was posted approximately four weeks after the reminder postcard, and its format was the same as the first, except for a different cover letter, and the absence of a Coded Response Postcard.

Each anonymous questionnaire was assigned a unique serial four-digit number as it was received, which served as a subject identification number. These had no association with the actual subjects' names or contact information. The Coded Response Postcards were individually labeled with a five-digit code before mailing, consisting of the year of graduation, and a three-digit identification number. The I.D. numbers were assigned in alphabetical order (e.g. Aaron Aarons from 1969 would be 69-001). A separate database was maintained with names and addresses to record which subjects had returned the Coded Response Postcard. The data were entered and analyzed using Microsoft Excel.

## DESIGN AND VARIABLES

The questionnaire was designed both to pose questions asked by previous researchers to the current study population, and also to investigate new relationships among several variables. It was designed to be brief: a single sheet, folded in half, to maximize response. To compare with previous published works, the questionnaire included demographic variables, a standardized questionnaire to assess attitudes toward homosexuality (HATH), several questions about medical practice habits, and questions about experiences with gay colleagues and acquaintances. In addition, questions were included about perceived adequacy of training in topics of sexuality, and about respondents' own sexual orientation. Finally, respondents who identified as lesbigay were asked to complete an additional section containing questions about "coming out" and about experiences of discrimination. The sections below detail each question, and whether it was original or was modeled after a previous study.

The questionnaire was piloted using 50 volunteers from an e-mail list focussing on topics of homosexuality in medicine. The penultimate version of the questionnaire were mailed to pilot subjects together with a stamped addressed envelope. Pilots provided feedback on grammatical errors and typos, and offered suggestions to clarify instructions and visually improve the questionnaire. The questions, however, remained unchanged.

### *Demographic Measures*

The following demographic measures were collected. These items were selected because previous studies have suggested correlations between each and attitudes toward homosexuality, and also to help determine whether the respondents are representative of the population of Yale Med graduates.

a) age

b) sex (M/F)

c) Year beginning YMS

d) Year graduated from YMS

e) Medical specialty (Family Practice/GP, Internal Medicine/Subsp, OB/GYN, Pediatrics/Ped Subsp, Psychiatry, Surgery/Surgical Subsp, Other -please specify)

f) Region (Northeast/East, South, West, Midwest/Mtn, Other -please specify)

g) Ethnicity (African-American, Caucasian, Hispanic/Latino, Asian/Pac.Island, Other - please specify)

h) Relationship status (Single, Married, Partnered, Divorced/Separated, Widowed)

Two variables were recoded for the purpose of analysis. The year of graduation variable was grouped into three categories: (1) Decade 1, 1969-1978, (2) Decade 2, 1979-1988, and (3) Decade 3, 1989-1998. The medical specialty "other" category was expanded into (1) Emergency Medicine, (2) Pathology/Radiology, and (3) Other.

### *Sexual Orientation Measures*

Sexual behavior and sexual identity are complicated constructs. For the purpose of this study, self-identification of orientation was determined to be more relevant than

actual sexual behavior, since most of the research cited for this project has used self-identified orientation as a primary measure. Therefore, questions regarding sexual behavior were not included. Since sexual behavior has also been shown to be fluid in some individuals (Kinsey), subjects were asked to describe their sexual orientation at two points in time.

a) Which most accurately describes your sexual orientation today? (Heterosexual, Bisexual, Homosexual, Other-please explain)

b) Which most accurately describes your sexual orientation in medical school? (Heterosexual, Bisexual, Homosexual, Other-please explain)

Due to the infrequency of the status and the small likelihood of any positive response, I chose not to include Transgendered as a separate variable.

### *Attitude Measures*

Researchers have used a variety of measures to assess attitudes toward homosexuality in the past three decades. The earliest researchers created their own questionnaires to measure specific attitudes, such as whether homosexuality is really a disease (Morris, 1973), and what are psychiatrists' attitudes toward lesbianism[70]. Several more general scales were developed and validated in the 1980's, including Larsen et al's 1983 Heterosexual's Attitudes Toward Homosexuals (HATH) scale, Douglas et al's 1985 Index of Homophobia Scale (IHP), and Bouton's 1987 Homophobia Scale.

The HATH was determined to be the most appropriate for the current study because of its small size (only 20 items v. IHP's 25),its prevalence in studies featured in the medical literature (including the Western Journal of Medicine, Family Medicine, and

the Journal of Family Practice), and its reliability and validity (alpha coefficient = .95; split half reliability coefficient = .92). This scale contains 20 items, rated on a Likert-type scale from Strongly Agree to Strongly Disagree. Minor modifications were made in fourteen of the twenty questions, where the term "homosexuals" was replaced with "gays and lesbians," in order to update the questionnaire's language to be more in line with the language of today's public discourse. Each of the items is scored from one to five, and the scores are summed to yield a HATH score, ranging from 20 to 100. The HATH scale rates respondents as "homophilic" or comfortable with homosexuality (20 to 49), neutral (50 to 69), and "homophobic" or uncomfortable with homosexuality (70 to 100). Larsen found the HATH scale to have satisfactory reliability and promising construct validity.

In addition to the HATH scale, another variable was included to measure attitudes specific to lesbigays in medicine: "Should a highly qualified gay/lesbian/bisexual applicant be admitted to Yale School of Medicine?" (Yes/No). This question was adapted from Mathews 1986, and has been used in two later studies as well, to assess strength of opposition to lesbigays in medical training.

Finally, two variables were included to assess attitudes toward Yale's education in sexuality and homosexuality: "How adequate was Yale School of Medicine's teaching on the topic of sexuality in general?" and "How adequate was Yale School of Medicine's teaching on the topic of homosexuality?" (Very Adequate, Adequate, Inadequate, Very Inadequate). These variables, although undeniably subjective, are included to help determine changing attitudes over time, and also to compare sexuality teaching in general, with specific homosexuality teaching.

### *Experience Measures*

Yale graduates' experiences with homosexuality were measured using seven self-report binary variables. Subjects were asked to respond Yes or No to each of the following questions:

a) Have you ever heard colleagues make disparaging remarks about gay, lesbian, or bisexual patients?

b) Have you observed colleagues providing reduced care or denying care to patients because of their sexual orientation?

c) Has a colleague ever told you he or she is gay/lesbian/bisexual?

d) Has a patient ever told you he or she is gay/lesbian/bisexual?

e) Has a friend or relative ever told you he or she is gay/lesbian/bisexual?

f) As a Yale medical student, did you personally know any gay/lesbian/bisexual students at Yale School of Medicine?

g) As a Yale medical student, did you personally know any gay/lesbian/bisexual faculty at Yale School of Medicine?

Questions a and b were initially used in the GLMA Report on Anti-Gay Discrimination in Medicine. Their purpose, in addition to comparison with the GLMA study, is to determine how commonly anti-gay comments and actions are witnessed in the medical setting. Questions c-g are original. They were included to determine each subjects' breadth of interaction with lesbigay patients, colleagues, and family & friends, to look for association between interaction with lesbigays and attitudes toward lesbigays. In addition, variables c-g were also analyzed with year of graduation data to provide a

profile of what kind of environment toward homosexuality prevailed at different times in Yale's past.

### *Practice Measures*

To explore the associations between medical practice, and attitudes and experiences, five questions were included. These questions were adapted from Gemson 1991, who surveyed New York primary care doctors about their practices to examine their AIDS-prevention practices. Each respondents was asked "When you meet a new patient,"

a) Do you ask whether they smoke? (Always, Usually, Sometimes, Rarely, Never)

b) Do you ask about their alcohol intake?

c) Do you ask about exercise?

d) Do you take a sexual history?

e) Do you ask about their sexual orientation?

While questions a through c are for comparative purposes, questions d and e are targeted to uncover practices related to the care of homosexual patients. It is noted that these questions may be less informative for specialties with minimal patient interaction (e.g. radiology), with targeted populations (e.g. pediatricians), or with limited practice fields (e.g. dermatology).

### *Experience Measures for Lesbigays*

Subjects who consider themselves homosexual or bisexual were asked to complete an additional section, detailing their experiences as lesbigay medical students and physicians. Three variables regarding disclosure or "coming out" were included.

a) When would you say you "came out" to yourself as gay/lesbian/bisexual? (before medical school, during medical school, during residency, after residency)

b) What percentage of your colleagues know that you are gay/lesbian/bisexual? (less than 10%, 10-19%, 20-49%, 50-89%, 90% or more)

c) As a medical student, what percentage of your classmates knew that you were gay/lesbian/bisexual? (less than 10%, 10-19%, 20-49%, 50-89%, 90% or more)

Question a is original, and is intended to help understand how the coming out experience might overlap with medical training. Question b was taken from the GLMA survey (1994), and is intended to measure how "out" a respondent chooses to be; question c is original and is intended to offer comparison between outness at different times in Yale's history, and to offer comparison between disclosure of orientation in the medical school setting as opposed to the professional setting.

Five more questions from the GLMA survey were included to measure experiences of mistreatment based on sexual orientation. Subjects were asked to respond Yes or No to the following: "Have you ever, because of your sexual orientation, been"

a) refused medical privileges, fired, or denied employment, education opportunities or a promotion?

b) denied a slot in or discouraged from entering a residency or fellowship program?

c) subjected to verbal harassment or insulted by colleagues?

d) socially ostracized by other physicians/medical students?

e) punched, kicked, beaten, or assaulted with a weapon?

In addition, subjects were invited to share further thoughts on the questionnaire topics on the Comments page at the end of the form.

## DATA ANALYSIS

In this study, I tested the associations between attitudes toward homosexuality and 1)decade of graduation, 2)sex, 3)sexual orientation, 4)specialty, and 5)probability of knowing gay students, faculty, patients, colleagues and family members. In addition, I tested the associations between decade of graduation and experiences with lesbigay colleagues, acquaintances, and patients. Chi-square analyses were used to determine statistical significance.

# RESULTS

## *Demographics*

Of the 2703 questionnaires mailed, 1086 were returned completed (40.2%), 10 were returned blank or written "refused" (0.4%), and the remaining 1607 (59.6%) did not return a survey. The age range of respondents was 26 to 66, with a mean of 42.4 years. All graduation years from 1969 through 1998 were represented, with response rates for each class varying from 28% to 52%. Respondents, representing the population of Yale graduates, were predominantly male (66.9%) and white (80.4%). The majority practice in the Northeastern or Eastern region (51.5%). More than half of respondents list their specialty as internal medicine/subspecialty or surgery/surgical subspecialty (29.6% and 24.5%, respectively), with the next most common being pediatrics/pediatric subspecialty (12.4%), and psychiatry (10.2%). Three-fourths (74.7%) are married.

Respondents and non-respondents did not differ significantly in terms of sex, or by decade of graduation. Respondents were representative in distribution of the eastern half of the country, but there were more respondents from the midwest, and more non-responders from the West. Data were not available to compare response rates by specialties.

## *Sexual Orientation*

The questionnaire asked respondents to indicate their sexual orientation at two time points: today, and as students at Yale School of Medicine. Seventy respondents currently identify as gay, lesbian, or bisexual (6.5%), and 4 as "other," including

"confused," "celibate," and "heterosexual but bi-curious." As medical students, 62 respondents, or 5.7%, identified as gay, although several noted they were very "closeted" at the time. Six identified as "other" in medical school. Overall, 73 respondents have identified as lesbigay in the past or present, representing all but one graduating class since 1969 (6.7%). Since lesbigays likely had a higher response rate than their peers, due to their personal interest in the topic of the questionnaire, this could be an overestimate of the true prevalence of lesbigays in the population of Yale Med graduates. However, even given the assumption that absolutely all of the non-responders were heterosexual (which is a very unlikely assumption), lesbigays would still make up almost 3% of all Yale School of Medicine graduates in the past three decades. The distribution of lesbigay graduates across the decades is not statistically different ($\chi^2 = .77$, df=2, p=.68). Of note, 31 respondents, or almost 3%, indicated a change in orientation between medical school and the time they filled out the questionnaire.

Some of the "other" responses were particularly candid, and highlighted how complex and difficult it can be to categorize sexual orientation. A young internist, who identified as bisexual in medical school, and heterosexual today, commented "I remain uneasy with categorization (homo/hetero/bi)... I never know what to say. Heterosexual experimenting? Bisexual? It's all a continuum...." A female pediatrician wrote, "I don't hold a single orientation as an 'identity'. Most would call me heterosexual, because all other things being equal, that's my 'preference'. But... all other things are not always equal! P.S. One of my closest friends has dubbed me an 'omnisexual'." A male

radiologist shared his struggles between his sexual feelings and his faith as a "confused" medical student:

> *"I had both homosexual and heterosexual experiences. This had been a major 'stress' in my life since my late teenage years. I was never comfortable with my 'sexuality' and didn't like the idea of classifying myself as homosexual or bisexual... I am currently married and have two children, and am very, very happy with my family life... I could not have experienced this wonderful blessing if I accepted homosexuality as a lifestyle. I do believe that homosexuality is immoral. I am a Christian and base my life and decisions on Christ's teachings. Although I would never mistreat a person based on their sexual orientation, I would strongly encourage any homosexual to read the scriptures, and would gladly share my own personal story with them. People with sexual 'issues' really need God in their life to help them with the answers. He has answered me and it has been a true miracle!!!"*

### *Attitudes*

HATH scores were computed for 976 respondents; the remaining 110 respondents are omitted from this analysis because they did not complete all the items on the HATH. Many of these people commented that they omitted certain items because they felt the items were ambiguous or might be misinterpreted. The average HATH score of respondents was 35.2, falling in the "homophilic" range as defined by Larsen, scoring from 20 to 49, which indicates comfort with homosexuality. Overall, 86.3% scored "homophilic," 12.7% "neutral" (between 50 and 69), and only 1% percent "homophobic"

(over 70). Significant differences emerged among respondents when stratified by specialty, sex, and sexual orientation, but not by decade of graduation ($\chi^2$=9.53, df=4, p=.05). The majority of respondents in every specialty scored in the homophilic range, with psychiatrists and family physicians having the lowest mean scores (29.2 and 31.3), and surgeons and pathologists/radiologists scoring the highest (41.7 and 36.2) ($\chi^2$=53.9, df=16, p<.001). In rank order, from lowest score (most accepting of lesbigays) to highest score (least accepting), the specialties are psychiatry, family practice, pediatrics, internal medicine, emergency medicine, obstetrics-gynecology, pathology/radiology, and surgery. Women scored significantly lower than men (31.6 v 36.8, $\chi^2$=14.31, df=2, p<.001), and not surprisingly, homosexuals and bisexuals scored significantly lower than heterosexuals (25.5 v 35.8, $\chi^2$=12.12, df=2, p=.002).

Specific HATH questions were also analyzed to provide for comparisons with previous studies. Only a handful of respondents (3%) agreed or strongly agreed with the statement "Homosexuality is a mental disorder," and these were more likely to have graduated in earlier decades. A 44yo pediatrician commented "I 'see' homosexuality as mostly a disease arising within a sick family & a crowded world." And 7% agreed or strongly agreed that homosexuality is a sin. Some acknowledge the challenge that this presents to them in caring for patients. "I find it difficult to reconcile my views as an MD with those generally professed by my religion (Christian-Presbyterian)." Others cope by simply ignoring any differences, evidenced by this surgeon's comment, "As you can tell from my answers, I consider homosexuality a sin. My approach to homosexual patients

is to treat them like heterosexual patients, so I'm not sure of the value of special sexuality training."

Very few respondents would deny acceptance to a highly qualified lesbigay applicant to Yale School of Medicine. Only 1.2% say they would deny acceptance, while several respondents checked neither yes nor no, but wrote in comments like "orientation should not make a difference one way or the other," and "not all highly qualified applicants get accepted anyway, orientation shouldn't play a part."

Respondents' attitudes toward their education in sexuality and homosexuality were assessed. Over half (59%) reported that Yale's teaching on the topic of sex was adequate or very adequate, while the inverse was true for Yale's teaching on the topic of homosexuality, where 58% felt that it was inadequate, or very inadequate. More recent graduates were significantly more likely to see their teaching on both topics as adequate, and a small majority (54%) of the graduates in the past decade even view Yale's teaching on homosexuality as adequate or very adequate. Comments revealed that the climate at Yale with regard to sexuality teaching underwent a transformation during the study period.

In the early 1970's, an elective was offered on Human Sexuality through Dr. Philip Sarrell, which covered many topics, including homosexuality. A number of graduates who attended this class complemented Dr. Sarrell's work, with comments like "the class was state of the art in knowledge and breadth," and "excellent curriculum." Others noted its limitations, "While I was at Yale there was very strong teaching & awareness of sexuality by Dr. Sarrell but the whole area was not ripe yet for extensive discussions about homosexuality."

By the 1980's, graduates note that teaching about male homosexuality began to make its way into the curriculum, primarily with relation to HIV disease. A graduate from the early 1990's, now practicing as a family physician, comments on how she never was taught practical sexuality lessons. "The fact is, sexuality education at Yale Med sucks. I am VERY frequently asked by patients how to make their sex life better, enjoy sex more, technique, etc. I can only answer them based on my own experience, and frankly, I'm a lot more of an expert on diabetes than sex. A GOOD, practical sex class (not just 'parasympathetic pants, sympathetic shorts' stupid stuff) is definitely needed."

Students began to take the initiative by the early 1990's, and organized their own colloquium on human sexuality. A piece written by a Yale Medical student and published in Pulse, the medical student section of JAMA, chronicled how the idea for the colloquium was nurtured and finally implemented with the full support of students and administration[71]. "The colloquium sparked thoughtful and open discussion among students and faculty alike. Afterward, our class appeared to have a genuine appreciation of the importance of understanding and being able to professionally handle issues of sexuality in clinical practice. Everyone who participated felt compelled, at least to some degree, to reexamine his or her own perspectives on human sexuality." At the same time, a number of graduates objected to including teaching of homosexuality at all in the medical curriculum. A 39yo surgeon states, "This is a highly complicated issue which does not belong in medical school curriculum anymore than religion/culture or personal beliefs like legalization of abortion. Med students are much too late in their personality development to be re-educated."

In general, lesbigay graduates themselves were much more critical of Yale sexuality teaching than their heterosexual counterparts; 69.6% saw the sexuality teaching as inadequate or very inadequate, and a full 87.1% said the teaching on homosexuality was poor. According to a lesbian radiologist, "They taught homophobia!" A 34yo lesbian internist, at Yale in the 1990's, commented " I don't recall one word about homosexuality while at Yale (or, for that matter, any teaching related to sexual history-taking)."

### *Experiences*

Several items that were originally featured in the Gay and Lesbian Medical Association's 1994 Report on Anti-Gay Discrimination were included in the questionnaire for comparison purposes. The majority of respondents in this study report hearing colleagues make disparaging remarks about gay, lesbian, or bisexual patients (55%). A graduate from the late 1980's recounts, "I have witnessed many a surgical attending make homophobic remarks, occasionally in front of gay/lesbian residents/students/even other faculty." Only 6.6% of respondents "have observed colleagues providing reduced care or denying care to patients because of their sexual orientation." A pediatrician who graduated in the mid-1990's recalls an event on rotation. "I heard surgery residents making gerbil jokes about a homosexual man with GI troubles. I privately told the chief surgical resident on the team that I did not think that was appropriate & he later discussed with the team that the joking was inappropriate & unacceptable." An infectious disease specialist notes, "Many of my patients are gay, and I do believe they are routinely discriminated against." And a dramatic story was

recounted by a 1994 graduate, about her first clerkship in medical school, which happened to be on surgery. She recalls a surgical resident refusing to enter the room of a gay patient, insisting "I'm from Texas – where I come from, we let people like that take care of themselves." Stunned, the student reported the resident, suffered a very poor review, and was turned away from surgery as a career forever.

In terms of personal interaction with lesbigays, Yale grads have a great deal of experience. Fully 88.5% have been told by a patient that he/she is lesbigay, 75.5% have a friend or family member who is lesbigay, and 64.5% have a colleague who has come out to them as lesbigay. While graduates from different decades were equally likely to have taken care of lesbigay patients, the more recent graduates were significantly more likely to know gay colleagues and gay friends or members than graduates from earlier years. Respondents who acknowledge having a lesbigay colleague, friend, or family member scored much lower on the HATH scale than their classmates who don't (33.43 v 43.32,.

To help assess the climate for lesbigays at Yale School of Medicine, respondents were also asked if they knew any gay students or faculty members when they were medical students. Overall, a large majority of respondents (70.5%) report knowing a lesbigay student during their time at Yale, and almost a third (32.2%) report knowing a lesbigay faculty member while they were students. Again, when separated by decade, significant differences emerge. Just under half of respondents from the first decade (49.8%) knew a lesbigay student, 69% from the second decade, and 89.8% of those in the third decade. The same was true for knowing a lesbigay faculty member, ranging from under a quarter in the first decade, to almost half in the third decade.

Comments help illustrate the positive effect that personal interaction with lesbigays has had for many graduates. From a 43yo internist: "I had very little experience with gay people at Yale... But in 11/81, I met my first AIDS patient, one of the first seen in NYC, and started many years of treating and being involved in the lives of gay men... My personal feelings went through a lot of changes of course - it makes a difference meeting the objects of discrimination and fear before one can get over these societal-derived biases - and it helps to meet their families, their devoted friends and lovers - so I was cleansed of all my ignorant fears." From a more recent graduate, "I believe that...my contact with several gay/lesbian students and colleagues at Yale helped me to be more accepting and comfortable with homosexuality in general." A psychiatrist reflects, "I think my attitudes about homosexuality have changed a lot since medical school (27 years ago) in that I was judgmental, narrow-minded and intolerant. The biggest case for my attitude change was simply meeting & getting to know people who are homosexual."

### *Practice Measures*

Practice measure responses varied greatly based on specialty, with pathologists/radiologists and pediatricians in particular omitting the section, noting that they have too little patient interaction to answer appropriately. Of all those who did respond, 80.9% always or usually ask new patients whether they smoke, 76.3% whether they drink, and 51.7% whether they exercise. However, a minority of respondents routinely ask their patients about sex. Just over a third say they take a sexual history

from new patients (36.1%); and only one in five (20.9%) says they ask about sexual orientation.

Specialties with greater patient interaction (excluding pediatrics) were considered separately, because these are the physicians to whom patients are most likely to present with a concern about sexuality; these included family practitioners, internists, obstetrician-gynecologists, and psychiatrists. Of note, no breakdown was available to determine which of these respondents practice general medicine versus subspecialty medicine. Overall, more than 90% always or usually ask new patients about smoking and drinking, and just over half (51.5%) say they always or usually take a sexual history. However, when asked about a specific component of the sexual history, namely sexual orientation, of those who say they take a sexual history, more than 40% don't routinely ask about sexual orientation, and over 10% say they "never" do. Obstetricians are the most likely to take a sexual history (85.4%), while internists were the least likely, with fewer than half always or usually taking a sexual history (44.9%). Psychiatrists were the most likely to ask about sexual orientation, with just over half (51.4%) always or usually asking. Psychiatrists showed the most consistency between sexual history taking and asking about orientation; seven of 8 psychiatrists who took a sexual history also asked about sexual orientation, compared with 3 in 5 family physicians, and about 1 in 2 internists and obstetrician-gynecologists.

A startlingly strong relationship emerged between history taking and knowing someone lesbigay. A physician who has a lesbigay colleague, friend or family member is three and a half times more likely to take a sexual history than someone who doesn't have a lesbigay acquaintance, and having a lesbigay colleague makes it six times more likely

that doctor will regularly ask patients about their sexual orientation ($\chi^2$ =55.23, df=1, p<.00001).

A number of respondents noted their own discomfort at taking sexual histories as a way of explaining why they don't do it more frequently. From a 1980's graduate: "To this day, I continue to be reticent about taking an adequate sexual history from or doing couples counseling with homosexual and bisexual patients for fear of seeming ignorant or naïve or causing unintended offense. In this arena, then, these patients do not get the same degree of thorough evaluation & treatment I believe I give to other patients. I'm afraid residency training in pediatrics & psychiatry did not expand upon the little I learned on the topic at Yale."

### *Experiences of Lesbigays*

Seventy-three respondents shared their experiences as lesbigay medical professionals by completing an additional set of questions. Many of the questions were modeled on those included in the GLMA's Report on Anti-Gay Discrimination in Medicine.

Most lesbigay respondents knew they were gay when they got to medical school or discovered their sexuality during medical school (28 people or 38.4% and 22 people or 30.1%, respectively). A small proportion, about 1 in 6 came out during residency, and even fewer, about 1 in 7 came out after residency. No significant differences in terms of coming out to themselves were detected by decade of graduation.

While medical students at Yale, most lesbigay respondents chose to remain "closeted"; 40 (58%) reported that less than ten percent of their classmates knew they

were lesbigay. There was a clear trend, though not reaching significance, for more recent graduates to be more out, and graduates from earlier years to have been more closeted. In the earliest decade studied, three quarters of respondents (18 of 24) report being "closeted" (<10% of classmates knew), in the second decade it fell to 58%, and the most recent decade, only 9 of 23 students (39%) were closeted. Conversely, only one of 24 students in the earliest decade was completely "out" (>90% of classmates knew), one in 10 were "out" in the middle decade, and one in four of the most recent graduates were completely "out."

In their current careers, respondents are considerably more open about their orientations. Today, 21.9% are essentially "out" in the workplace, and another quarter say that the majority of their colleagues (50% to 89%) know they're lesbigay. Still, 35.6% of lesbigay respondents continue to be closeted at work today (26 of 73 respondents). By way of explanation, more than half of these closeted respondents consider themselves bisexual, compared with 37.7% of all lesbigay respondents; and more than half of these bisexuals are currently married.

Discrimination based on sexual orientation, while not as common as previous studies suggested, has affected more than a third (35.6%) of lesbigay Yale Med graduates. The most common occurrence of discrimination was verbal harassment or insults from colleagues, which one fifth of respondents report. One in six reports being socially ostracized by colleagues, and 1 in 9 reports job-related discrimination, having been either denied a position, fired, or passed over for a promotion.

Finally, a shocking 5 respondents (6.6%) report having been "punched, kicked, beaten, or assaulted with a weapon" as a result of their sexual orientation. A psychiatrist

from the 1980's recounted a terrifying recent experience. He lives in a neighborhood with a high concentration of gays, which has tended to make him feel quite safe. One evening, however, walking home from buying groceries at his neighborhood market, he was attacked by two men who knocked him down, and punched and kicked him about the head yelling "faggot!" until he lost consciousness. His wallet was not taken, indicating that rather than a robbery, this was intended as a hate crime. This incident proves that even lesbigays in high-status occupations are not immune from the discrimination and the risk of violence that plagues all lesbigay individuals across the country.

Some episodes of harassment experienced by lesbigay graduates did not fall into any of the above categories, but rather consisted of undirected actions which created a hostile and unwelcoming environment for lesbigays. While no numeric data were collected for this type of harassment, respondents did volunteer comments describing the harassment. Several of these accountings are presented below.

In the early years of meetings for the gay group on campus, according to an early group leader, their posters were repeatedly torn down shortly after they went up. Another example, later incorporated into a sensitivity workshop sponsored by the Office of Education, showed graffiti that had been written at the bottom of an AIDS education poster in the medical school dormitory elevator. The poster, which depicted two men, was defaced with the following handwritten comment: (Figure 1)

**Figure 1: An example of Anti-gay graffiti on Yale Med campus, early 1990's**

A very well documented incident from 1993 illustrates the administration's response to a harassing incident on campus. A gay respondent sent these materials along with his questionnaire. As a medical student, he had noticed an article posted on the official bulletin board for First Year Student Announcements. An excerpt from the student's response letter to the Dean for Student Affairs follows:

> "I feel strongly that the posting of the enclosed xerox of the article 'An Unusual Body in the Rectum – A Baseball', was an inappropriate use of this board, and reflects an insensitivity that causes me great concern as a member of the Yale Medical community. In particular, I am especially offended by whoever posted the flyer's highlighting of a paragraph in which the patient explains that the baseball was placed in his rectum because he's 'oversexed' and by the handwritten message 'Do Not Remove (this flyer)'... To me this action is homophobic because the added highlighted and handwritten emphasis suggests that the person who posted this flyer did so not with the purpose of presenting an unusual and interesting clinical problem... but rather with the purpose of poking

fun at a very real but not wholly representative aspect of male homosexual behavior."

Four days later, the Dean of Students Affairs himself responded, "Thank you very much for calling my attention to the offensive article … it represents a gross example of homophobia and I am incensed by it… I pledge to you that I will bring your letter to the Minority Affairs Committee to discuss any appropriate response… I can assure you that I will, at every opportunity, continue to speak out in support of gay, lesbian, and bisexual rights and to express my abhorrence at such acts of intolerance."

The personal stories of lesbigay graduates shed light on the complexities of coming to terms with one's sexual orientation while still trying to succeed in the medical community. Some of these stories are presented below.

A 56yo Pediatrician recounted the struggles he encountered as medical student grappling with his sexual identity in the years before the APA voted to de-medicalize homosexuality.

*"I thought I was sick from when I first felt attracted to men until I came out at age 34. I am probably residually and deeply ashamed to be gay but not in principle. It is a feeling I will always live with. When I was at Yale I went to William Sloan Coffin, the Chaplain, with my worries. The contact was completely useless. I went to student health and started seeing a psychologist because I believed Freud (and others) that gays had 'failed' to attain some early competency in a stage of development. I ended up being psychoanalyzed by Daniel Schwartz, then the director of YPI. Through a 3 year analysis and the previous psychotherapy, it was never suggested that I accept being gay or that it*

*could be good. I became severely depressed and had to be in the YPI for a few days. I made it however, through school, and went on to a very complex life sexually. Most of my oppression has been internalized, not because I was especially aware of homophobia growing up but because I never knew a single example of a homosexual adult who was out, accepted, and considered well and happy. I just did not think it was possible to live as a homosexual."*

A bisexual internist from the 1970's recalls.

*"I was quite confused when I entered medical school. I 'came out' in my sophomore year and led a gay lifestyle for nearly twelve years. Then I met a woman with whom I fell in love. I married, and though the marriage ended in divorce thirteen years later, I have happily remarried and never looked back. The only discrimination I faced at Yale Med was my surgical prof at WHVA, Brill Storer, and Elijah Atkins, acting Dean of Student Affairs. To this day, I won't give Yale Med one cent because of the Hell Atkins put me through!"*

A gay pediatrician from the 1960's witnessed how vulnerable lesbigay medical students can be.

*"I may be one of the more visible YSM graduates (at least in terms of international recognition in science). When I was a student, gay life was rather hidden and certainly something one did not openly declare in society in general and in medical schools particularly. My main concern during these years was two suicides (not in my class but two other classes at Yale Medical School). These suicides seemed to me then and particularly now suicides over problems with sexual orientation (one man and one woman). I knew both but my suspicion*

*that they might be gay remained a suspicion even then because one did not 'ask' in those days. My concern today that suicide over sexual orientation, which is a well-established basis in teenagers, might extend to medical students, although the incidence is likely much lower."*

A bisexual family physician from the 1970's was brave enough to share his sexual feelings in a classroom setting, but was not welcomed.

*"I started to open the issue of my ambiguous sexual orientation during the small group sexuality sessions at YMS for the first time. This disclosure was received with substantial discomfort by my fellow students and I was hesitant to bring it up again. I don't think I did. I live now in a pleasurable committed relationship and have never had the courage or energy to open this side of myself to others with the exception of my wife and one empathetic heterosexual colleague."*

A 45yo "other" pediatrician described the climate of fear that surrounded lesbigays in the 1980's.

*"During a post-graduate fellowship at Yale Medical School, I was aware that one of my colleagues came alone to social events in our department because of this colleague's belief - accurate in my opinion - that to come with a same-sex partner to these events would jeopardize one's career. I considered this a tragedy at the time and hope that your questionnaire will be among the forces to erode discrimination and bias against those of unusual (i.e. non-opposite sex only) sexual orientations."*

A gay obstetrician-gynecologist from the 1990's recalls being exposed to homophobia, even though no one knew he was gay.

*"During my time at Yale, I was subjected to numerous disparaging comments concerning gays, & homosexuality as a 'lifestyle preference', which were intolerant, close-minded, & brazenly prejudicial - primarily because most faculty, staff, and students never suspected I was gay. Many of the comments would qualify as harassment under already existing state laws, but at the time, I felt that the school did not really support gays/lesbians as a 'legitimate' minority, and thus, never pursued anything to 'protect' my career. The office of the ombudsperson was completely ineffective in representing the concerns of gays or ensuring a safe environment from which to advocate for change. Unfortunately, many of the prejudicial attitudes I encountered came from people who were in some way already members of some 'other' minority group & should REALLY know better, including current students."*

Not all lesbigay respondents looks back on their years at Yale quite so negatively. A lesbian psychiatrist recalls her positive experience being "out" in medical school in the 1970`s.

*"I can say I was absolutely totally "out" and public throughout medical school and residency. There was another openly gay woman in the class - we were friends. It caused a significant reaction when I danced with my partner at a department party during my residency at Yale! When I interviewed for my fellowship, I was asked if I felt I could 'fit in' with the group. (P.S. I was accepted)"*

Finally, a brave graduate from the 1990's decided to come out to his class en masse, during a Human Sexuality workshop. As he tells it,

*"As I stepped onto the stage, I blocked from my mind the significance of this moment and concentrated on the message that I wanted to deliver... Over three semesters, I had come out to seven classmates, the Dean, and our Chaplain, like a cautious swimmer who sticks his toe in the river to feel the temperature and strength of the undertow. As I contemplated jumping in with both feet, I considered the impact I could have on my colleagues, the freedom I would gain to express myself openly and honestly, and the foundation I would establish upon which to continue promoting tolerance and understanding... As I reflect on the feeling of leaving the stage to thunderous applause and a swell of emotional and supportive classmates around me, I realize the magnitude of what I have done for them and for myself. By taking this confident step toward becoming an openly gay physician, the "leader by example" that I want so very much to be, I have earned the respect of my peers who ... thank me for making sensitivity to sexual orientation have personal meaning in their lives."*

### *Refusals*

Three mailings were returned unopened, with "return to sender-refused" written on them. Seven refusals were returned via uncompleted questionnaires, and a single refuser contacted the Dean of the Yale School of Medicine by telephone to express his displeasure at receiving the questionnaire. Of note, all but one of the questionnaire refusals were sent back on the second mailing (as determined by the cover letter), indicating that these refusers had ignored the initial mailing and follow-up postcard. Of

the seven mailed refusals, four were returned with neutral comments, including "not interested" and "refused," or with no comments at all. However, despite one lesbian respondent's confidently written comment, "Yale grads are too sophisticated to have blatant prejudice," the remaining three refusers returned blank forms with incendiary comments, recounted below, and reproduced in Appendix C.

1. *"Please don't send this trash to (responder's name) again. No thank you!"*
2. *"You want 'disparaging remarks'? Quit wasting my time, & soiling the reputation of my medical school, by distributing this crap. In addition to being inherently offensive, it represents 'junk science' at its worst. The attitudes & experiences of a small group of Yale Med students (& even this distorted by selective participation), has absolutely no relevance for the rest of the world. I hope this garbage doesn't pass for thesis material at Yale today. (Though I guess it wouldn't surprise me; were it turned down, the outcry of 'homophobia' would be deafening, just as the fags and lesbians whine about everything else)"*
3. The final, and most surprising refusal comment was written largely in black marker.

*"GO FUCK YOURSELF ASSHOLE!!"*

# DISCUSSION

This is the first study of its kind to elicit attitudes toward and experiences with homosexuality in the medical profession among a distinct population of physicians trained at a single elite medical school. In all, over a thousand physicians representing 40% of the known living graduates of Yale School of Medicine from 1969 through 1998 replied to a mailed questionnaire entitled "Lesbian, Bisexual, and Gay Graduates of the Yale School of Medicine, and their Heterosexual Peers: Attitudes and Experiences, 1969-1998." In light of the controversial topic and the personal nature of several questionnaire items, the response rate was higher than expected. This represents an acceptable response rate, as the respondents were representative of the population in terms of sex, and year of graduation, although Westerners were slightly over-represented as compared to Midwesterners.

## *Findings*

The major findings of this study are as follows.

- Yale grads from the past three decades report markedly less bias against homosexuals than any previous study of medical professionals in the published literature, with only 1% scoring in the "homophobic" range on a standardized scale.
- Physicians who a have lesbigay colleague, friend, or family member are significantly more positive toward homosexuality than those who don't.
- Psychiatry and family practice appear to be the most tolerant specialties, and surgery and radiology/pathology the least.

- Lesbian, bisexuals, and gay men have been a consistent part of the Yale School of Medicine community for the past thirty years, with a prevalence of 6.5%, and a lifetime prevalence of 6.8%.
- Almost a third of Yale graduates who consider themselves lesbigay "came out" to themselves after graduating from medical school, and approximately 3% of all graduates have changed how they describe their sexual orientation between medical school and the present.
- Teaching of sexuality topics has improved at Yale, but still needs improving, with almost two thirds agreeing that Yale's teaching of sexuality is adequate, and just over half agreeing that homosexuality teaching is adequate. In particular, teaching of sexual history taking is poor, and less than a third of grads in high patient-interaction field routinely ask their patients about sexual orientation.
- Graduates with more tolerant views toward homosexuality are significantly more likely to ask their patients about sexual history and orientation, and those with a lesbigay acquaintance are six times more likely to routinely ask about sexual orientation than those without.
- The Yale School of Medicine environment has become increasingly tolerant of openly homosexual students; of recent graduates, over 96 % know a lesbigay Yale Med student.
- Compared with previous studies, lesbigay Yale grads have experienced less discrimination and harassment than their lesbigay peers, although 36% report some harassment and 7% report physical assault due to their sexual orientation.

- Strong anti-gay sentiments persist even among highly educated individuals, as is evidenced by three graduates who returned hostile refusals to the author, including those with foul language such as "go f*** yourself a**hole!"

A detailed discussion of the findings follows.

## Sexual Orientation

In the first finding of its kind, a count was made of the number of lesbigay graduates of an elite medical school. Gay men, lesbians, and bisexuals have comprised an estimated 3% to 7% of all graduates from the Yale School of Medicine in the past three decades. For comparison purposes, this proportion represents more lesbigay students than other recognized minority groups at Yale, including Hispanics and Native Americans. A surprising finding was that 3% of respondents changed their orientation designation between medical school and the present. This topic has not been addressed at all in any of the literature on attitudes toward homosexuality, or homosexuality in the medical profession, and most certainly has not been addressed in curriculum development. In fact, most previous studies on physicians' attitudes toward homosexuality have omitted asking sexual orientation, at least sometimes for fear that it would "adversely affect the overall response rate" (Mathews).

## Attitudes

The present study found substantially less bias against lesbigays in medicine than has been reported in previous studies in the past three decades. In particular, scores on

the HATH scale, measuring attitudes toward homosexuality, were the lowest yet published in the medical literature. The current study shows that only 1% of Yale physicians responding scored in the "homophobic" range, compared with 22.9% in Mathews' 1982 study of Southern California physicians, 12.8% in Prichard's 1988 study of Southern California family practice residents, and 8% in Oriel's 1994 national study of family practice residency directors.

**Table 2: Heterosexual Attitides Toward Homosexual scores, and type of responding subjects**

| | N | Subjects | % Homophilic | % Neutral | % Homophobic |
|---|---|---|---|---|---|
| Mathews 1986 | 930 | Calif. Med Society | 37.0 | 40.1 | 22.9 |
| Prichard 1988 | 117 | Fam Med Resident | 62.4 | 24.8 | 12.8 |
| Oriel 1996 | 282 | Fam Med Res Dir | 67 | 25 | 8 |
| Rubineau 2000 | 976 | Yale Med Grads | 86.3 | 12.7 | 1 |

Dramatic and significant differences in attitudes toward homosexuality emerged when results were stratified by sex, by sexual orientation, and by specialty; and differences in experiences with homosexuality emerged when stratified by year of graduation. Unlike previous studies, no significant differences in attitudes emerged by decade of graduation, although there was a trend toward lower HATH scores in later graduates, and a trend toward agreeing with the statement "Homosexuality is a mental disorder" among earlier graduates. Like previous studies (Mathews, Douglas, Prichard, Wallack, Oriel), women were significantly less homophobic than men. Also similar to previous studies, surgeons and radiologists/pathologists are the most homophobic specialties. However, while previous studies have suggested that family physicians are

among the more homophobic specialties, the Yale family physicians have very low HATH scores, second only to psychiatry, the specialty which all studies show to be the most tolerant toward lesbigays.

When asked about whether a qualified lesbigay applicant should be admitted to Yale School of Medicine, Yale respondents again differed greatly from previous studies. While Mathews, Prichard, and Ramos published rates ranging from almost 30% to 4.3%, only 1.2% of Yale physicians said they would refuse admission to a gay candidate, including only a single member of the most recent decade's graduates. Given that Yale has a non-discrimination clause featuring sexual orientation, and an out lesbigay faculty member on the admissions committee, this very low response is particularly encouraging.

The lack of significant differences in decade of graduation and attitude has several plausible explanations. Perhaps it represents an attitudinal shift that has come about in the past several years, both in the medical community and in society as a whole. This would imply that had we asked the same questions of the same subjects ten years ago, their answers would have been more biased against lesbigays. As one comment from a 54yo internist illustrates, "Some of these answers reflect feelings in 1999. 20 yrs ago my answers would probably have been different." After all, the climate of the nation as a whole has shifted to more tolerance toward homosexuality, as is evidenced by numerous new laws protecting the rights of lesbigays, and by lesbigay characters appearing more frequently in the media and more and more celebrities disclosing their homosexuality.

Another explanation for the difference could be that the trend toward less biased attitudes toward lesbigays, first described by Mathews, has simply continued. The eldest group in the Mathews study, which established the relationship between attitude and

graduation year, graduated from medical school between 1970 and 1981. This cohort corresponds to the oldest group in the present study, which graduated between 1969 and 1978. However, even when this cohort is compared to its parallel in Yale graduates, the Yale graduates still score lower. Data are not available to determine whether this could be explained by regional differences, or by a different distribution among the specialties.

However, together with the other finding that respondents who know gay colleagues, friends, or family are more tolerant of gays than those who don't, it leads to a third possible explanation. Perhaps as more lesbigays disclose their orientation to their family, friends, and colleagues, more doctors will know lesbigay people personally, and their attitudes will then be shaped in a more tolerant direction.

Most likely is that all of these factors are contributing to some degree to this observed decrease in negative attitudes among Yale graduates toward homosexuality.

## Practice Measures

Earlier sections have demonstrated that communication with lesbigay patients is an important indicator of health and satisfaction with medical care. Nevertheless, only a slight majority of responding physicians in fields with high patient interaction routinely takes a sexual history. At least as disturbing is that two-fifths of those who do take sexual histories don't routinely ask about sexual orientation, even though asking the gender of a patient's sexual partners is considered an integral part of sexual history-taking. In fact, several respondents expressed their belief that sexual orientation is not relevant to medical care: "I think most people of alternative lifestyles especially those who are closeted would prefer sex not even be an issue in a professional setting such as

patient/doctor relationship." -A 36yo surgeon. Another respondent who rarely asks sexual orientation comments that she treats her homosexual patients just like heterosexuals, so there is no need to distinguish. At the same time, a number of respondents expressed their discomfort at taking sexual histories, saying that they felt poorly equipped and awkward, and that were worried they might "look stupid" when interacting with lesbigay patients.

These findings are consistent with Gemson 1991 who surveyed 473 internists, family physicians, and obstetrician-gynecologists to determine AIDS prevention practices, and found that 58% routinely take sexual history, and 39% ask about sexual orientation. Together with the feedback generated by the questions on sexuality teaching at Yale, this suggests that Yale graduates in general either are not informed on the importance of complete sexual history taking, or have not had enough practice in it to feel comfortable incorporating such questions into their patient care.

Experiences of Lesbigay Yale Med Grads.

Never before have the personal stories of lesbian, bisexual, and gay physicians been gathered and presented in such detail. They reveal struggles and fears, confusion and anger, humor and triumphs. They represent a diverse array of men and women, in all specialties, some living very openly gay, in urban areas, taking care of HIV patients, while others live quiet, closeted lives, in small towns. What they have in common is the shared memory of their years at Yale School of Medicine.

At Yale: Although lesbigays have been represented in virtually all graduating classes from the past thirty years, their visibility has changed greatly over the years. The climate in the 1960's and 1970's is described as "secretive," "closeted," and "illicit."

Lesbigay students had no social group, no protective non-discrimination clauses, and their concerns were not even addressed as part of the standard curriculum. Just under half of their straight classmates could even name a lesbigay medical student. Through the 1980's, and the rise of the AIDS epidemic, homosexuality (male homosexuality at least) became a more salient topic in the medical world, and teachers began to address the topic more often in class. The first group for lesbigays at Yale Med, called GLHPAY (Gay and Lesbian Health Professionals at Yale) started to meet secretly, and over 70% of the straight medical students could point to a lesbigay Yalie. The 1990`s saw even more progress for lesbigays, as a bisexual student was featured in the recruitment brochures put out by the multicultural education office, and as a gay student led a successful petition drive to include sexual orientation in the Yale Physician's Oath, recited by all graduating students. And by the last half of the 1990's, 97% of grads can identify a lesbigay classmate.

Since Yale: When compared with the respondents from the GLMA`s landmark 1992 study on Anti-Gay Discrimination in Medicine, the Yale population is more male (62% v 73%) and has more people living near the coasts (80% v 61%). The Yale graduates report substantially less discrimination than seen in the GLMA study in all arenas, except for discrimination in residency or fellowship selection, where 11% of both populations answered yes. Yale grads were half as likely to experience social ostracization, and half as likely to be victims of gay-bashing. Overall, 56% of the GLMA's surveyed physicians report some kind of professional or economic discrimination, while 36% of lesbigay Yale grads report the same.

The GLMA report was based on a survey of 711 of its members, all of whom were physicians or medical students who chose to affiliate with a national gay-related medical association. It's not surprising then to find that slightly more of the GLMA respondents are "out" (24% v 22%), and much fewer of them are closeted (22% v 36%). In the present study, out physicians and closeted physicians were equally likely to experience discrimination (44% v 40%) ($p>.05$), compared with the GLMA study, which found that out physicians experienced substantially more discrimination in all realms than their closeted colleagues. The numbers for the current study were not sufficient to allow for comparisons with the GLMA study in terms of discrimination by specialty.

### *Limitations*

The greatest limitation to this study is the response rate of 40%. When compared with the study this most resembles, Mathews 1986 (a study of 2,364 members of all specialties and ages of a California Medical Society), the response rates are remarkable similar (42.7% for Mathews v 40.25 for the current study). This even takes into account that Mathews deliberately chose not to include a measure asking sexual orientation for fear that it would adversely affect response rate. Response rates for other similar studies of physicians' attitudes toward homosexuality have varied 53.6% to 59.7%. Another unique feature of the current study is that it is of a fixed population that has been followed by the development office over time; therefore, unlike active residents and faculty, or members of a medical society, addresses in the database may not be as accurate as those used by previous researchers.

More important than the number of questionnaires returned, however, is whether those who did respond are actually representative of the population as a whole. It has been determined that in major categories which have been showed to be associated with attitudes toward homosexuality, namely sex and year of graduation, the respondents were no different than the non-respondents. However, caution is warranted in analyzing the data, since it cannot be determined whether the attitudes of respondents are representative of the attitudes of the population. On the one hand, it is likely that lesbigay respondents themselves may be over-represented in the sample, since they may have more personal investment in the outcome of the study, and therefore have a higher motivation for returning the survey. Since the 73 lesbigay respondents reported more tolerant views toward homosexuality, it is possible that their over-representation could skew the results in a more gay-positive direction. On the other hand, at least 11 refusers returned blank questionnaires; therefore they were not included in the analyses. Several of these refusers expressed strongly negative views toward homosexuality, and would have demonstrated these had they completed the questionnaires. Therefore, it is expected that a significant portion of the non-responders were represented by the refusers, and if their responses had been included, it would have affected the overall outcome toward less tolerant views of homosexuality. Despite these limitations, the findings of this study are important and relevant to the Yale School of Medicine community, to lesbigay physicians and patients, and to the medical education and medical practice communities at large.

Another limitation of the study was a number of people's concern over anonymity. Despite the assurances by the author, a number of respondents left several demographic items blank, and commented that given the small size of graduating classes,

and the postmark on the envelope, it would be possible in many cases to narrow the identity of any respondent down to just a few, or even to just one graduate. It cannot be determined whether those who chose not to respond for fear of losing anonymity may have been more representative of severely closeted lesbigay respondents (who feared being "outed"), or of straight respondents with strongly anti-gay views, who feared repercussions from expressing such views to a researcher. In truth, since all questionnaires were separated from their envelopes and numbered before the data were examined, this type of identification would not have been possible. Nevertheless, the value of collecting this demographic information outweighed the risks. In future studies, this concern could be addressed by breaking graduation year down into decades for respondents to check off.

A third limitation to the study is the limitation of the main measure itself: the HATH scale. Approximately 15% of respondents offered comments about the content and wording of many questions on the scale, not realizing that I had not written it myself. Several of the questions, particularly questions 12 "Gays need psychological treatment", and 19 "There should be no restrictions on homosexuality", were omitted by many people because they were viewed as ambiguous. This, together with the fact that the scale has been generating less variability among the respondents since its earliest administrations, suggests that the HATH scale may not be the best way to assess attitudes that have become more nuanced and subtle in recent years.

A fourth limitation to the study is the small absolute size of the lesbigay sample, which did not allow for statistical inferences of experiences based on specialty.

## RECOMMENDATIONS

The present study offers encouraging news about physicians' attitudes toward homosexuality. Lesbigay Yale Med students are coming out in record numbers, and many of their experiences have been quite positive. The Yale School of Medicine administration has shown increasing support for lesbigay issues, and its graduates have displayed the least homophobia of any group of physicians ever published. At the same time, this study offers sobering statistics about how the medical establishment in general and medical school in particular have failed to address directly the needs and concerns of lesbigay patients and doctors. Several of the most powerful findings from the study are recounted here, along with recommendations to address them.

*Lesbigays make up no less than 3% and as much as 7% of graduates from Yale Med.* This figure is substantial, and speaks to Yale's responsibility to specifically address the unique concerns of this group. Such actions would include continuing to support the Lambda Health Alliance for lesbigay health professionals at Yale, continuing to feature lesbigay applicants in recruitment materials, and continuing to work to incorporate lesbigay health issues into curriculum. In addition, Yale could take steps to reach out to its lesbigay alumni, through continuing education offers, or even by establishing a Lesbigay Alumni Mentoring program through the Office for Multicultural Affairs. In addition, Yale could choose to feature some of the findings from the current study in its own publications, including the alumni magazine, Yale Medicine.

*Respondents with a lesbigay acquaintance are more likely to hold positive views toward homosexuality, and are much more likely to talk to their patients about sex and*

*sexual orientation.* While the causation has not yet been determined, the correlation is clear. People who know lesbigays are more tolerant of lesbigays, and likely give better care to their lesbigay patients. It stands to reason, then, that Yale should work at increasing students' exposure to lesbigays. This can be accomplished by supporting openly lesbigay faculty as lecturers and presenters, and by continuing to encourage lesbigay applicants to apply and to attend Yale School of Medicine.

*Sexuality teaching at Yale has been irregular and incomplete.* Student comments about sexuality teaching at Yale reveal that too often, the students themselves have been responsible for coordinating and presenting this important topic. In most other medical schools, responsibility for teaching sexuality falls under the auspices of the Family Medicine Department (which Yale does not have), or the Psychiatry Deparment. Such accountability at Yale would help ensure continuity in sexuality teaching at Yale. In addition, rather than shrinking the time allotted to this important topic as has been done in recent years, sexuality teaching must be expanded. This should include both in-depth sessions on sexual history-taking, including role plays, and also more broad incorporation of how sexual concerns interact with overall health.

*Even Yale is not immune to blatant anti-gay attitudes.* As evidenced some of the refusals, and by stories recounted by students, some Yale graduates and Yale faculty continue to hold and express vehemently anti-gay attitudes. These examples need to be made public, along with Yale's firm and strong assertion that they will not be tolerated.

*Some specialties are decidedly more homophobic than others.* Consistently in multiple studies, surgeons, pathologists, radiologists, and obstetrician-gynecologists display the most negative attitudes toward homosexuality of all specialties. This should

not be tolerated. Rather, this provides Yale with an opportunity to offer workshops targetted toward the departments most in need of changing attitudes. Taking into account previous findings that those who know lesbigay colleagues are less likely to be homophobic, this could be accomplished by recruiting lesbigays from within those specialties to address their colleagues directly on the topic of homosexuality.

# APPENDICES

Appendix A: HIC Protocol Approval

Appendix B: Questionnaire forms, envelopes, and postcards

Appendix C: Selected Refusals

# Appendix A: HIC Protocol Approval

HIC # 11,050

**PROTOCOL FOR RESEARCH INVOLVING HUMAN SUBJECTS**
**YALE UNIVERSITY SCHOOL OF MEDICINE**
**YALE-NEW HAVEN HOSPITAL**

TITLE OF PROJECT: Lesbian, Gay and Bisexual Graduates of the Yale University School of Medicine: Attitudes and Experiences, 1969-1998. and their Heterosexual Peers DATE:_____

Principal Investigator: A.J. Babineau, YMS IV

Other Investigator(s):

Mailing Address: 473 Chestnut Hill Ave Brookline MA 02139 Tel. Ext._____

APPROVED FOR SUBMISSION TO HIC:

Signature of Primary Reviewer 6/3/99

Check if applicable:

___ Use of CRC
___ Use of Radioisotopes

SCHOOL AND HOSPITAL DEPARTMENT(s)

_____
Signature of Chairman, Department of

_____
Signature of Chairman, Department of

_____
Signature of Chairman, Department of

Research Subjects:

___ Minors
___ Fetuses
___ Abortuses
___ Pregnant Women
___ Prisoners
___ Mentally retarded
___ disabled

Funding Source:_____

___ Related to FDA:
IND #_____
IDE #_____A___B___
Industrial Sponsor:

**ATTENTION: Before completing this protocol, consult HIC Guidelines (revised 1993).**

**For HIC Use Only**

JUL 07 1999
Date Approved

for Human Investigation Committee

Appendix B: Questionnaire forms, envelopes, and postcards

*Lux et Veritas* *Sex at Yale*
A.J. Rubineau P.O. Box 6071 Hamden CT 06517

*Lux et Veritas* *Sex at Yale*
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**REMINDER POSTCARD**

Dear Yale Med Grad,

Last week, I mailed to you a brief questionnaire about your thoughts on sex. As a graduate of YMS, your individual perspective on the topic is crucial to the success of this study. If you've already finished the questionnaire and returned it, please accept my sincerest thanks. If not, I ask you to please take five minutes now to fill it out, and to drop it in the mail.

I appreciate your participation in the study, and I look forward to receiving your completed questionnaire. Please contact me at the number or e-mail below if you have any questions or concerns. Thank you again for your time.

Sincerely,

A.J. Rubineau, Yale Medical Student
(617) 277-4280 aj@alum.mit.edu

# Appendix C: Selected Refusals

# COMMENTS:

***Please use the following space to share any further thoughts on the questionnaire, on gays and lesbians in medicine, on gays and lesbians at Yale, or any related topic. Thank you again for your time.***

You want "disparaging remarks"? Quit wasting my time, & soiling the reputation of my (medical school, but distributing this crap

In addition to being inherently offensive, it represents "pink science" at its worst. The attitudes & experiences of a small group of Yale Med students (& even this distorted by selective participation), has absolutely no relevance for the rest of the world.

I hope this garbage doesn't pass for thesis material at Yale today. Though I guess it wouldn't surprise me; were it turned down, the outcry of "homophobia" would be deafening, just as the fags & lesbos whine about everything else

**Thank you!**

# COMMENTS:

***Please use the following space to share any further thoughts on the questionnaire, on gays and lesbians in medicine, on gays and lesbians at Yale, or any related topic. Thank you again for your time.***

GO FUCK YOURSELF ASSHOLE!!

***Thank you!***

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